# Homelessness in Urban America:

# A Review of the Literature

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## Abstract

In the 1980s, homelessness attracted a great deal of attention from the media, advocates, politicians, and the public. Every level of government responded to the visibly growing problem. Virtually every sector of society intervened. Interest in the issue seems to have waned considerably since then, but the problem continues to grow, particularly in large urban areas. Temporary homelessness has increased from a decade ago and threatens individuals and families further up the income distribution. Public policies continue to address the problem, but the nature and scale of the responses have changed.

Early state and federal policies were appropriate for what was viewed as a temporary result of economic recession—providing shelter and provisions to the homeless. These efforts expanded to prevent the growth of homelessness and create long-term housing for the chronically disabled homeless. Today these trends continue, accompanied by efforts in revitalized urban areas to restrict the visibility and behavior of the homeless. When shelter and resources seem abundant, housed citizens are often frustrated when the highly visible homeless refuse to use local service programs. Perhaps as a result, they support punitive policies that criminalize activities such as sleeping or panhandling in public places.

Homeless policy is at a crossroads. We can improve the availability and mix of service programs and encourage the chronic homeless to use them, or we can give up on those reluctant to seek help and try to make them less visible. We can grapple with the question of whether policies should do more to address the structural determinants of homelessness—which many claim lead to both new and repeated episodes of homelessness.

We have a wealth of information about the homeless population and their needs, and a growing body of research on the effectiveness of alternative solutions. There are many potential responses, but the current economic prosperity and budget surpluses provide the ideal setting for expanded and innovative efforts to address this old social problem.

# *Homelessness in Urban America:*
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### Section I: Introduction

In the 1980s, homelessness attracted a great deal of attention from the media, advocates, general public, and politicians. Policy responses to the visibly growing problem emerged at all levels of government. Organizations representing all sectors sponsored interventions. Though national interest in the issue seems to have waned considerably since then, the problem continues to grow, particularly in large urban areas. The likelihood of experiencing at least temporary homelessness has increased from a decade ago. Today it threatens individuals and families further up the income distribution. Public policies continue to address the problem, but the nature and scale of these responses has changed over time.

Early state and federal policies were an appropriate response for what was viewed as a temporary crisis related to an economic recession—providing shelter and provisions (food, clothing, and medical care) to assuage the harm caused by homelessness. Eventually these efforts expanded to provide transitional and other specialized assistance aimed at preventing further bouts of homelessness and to create cost-effective long-term housing for the chronically disabled homeless. Today we see a continuation of these trends but increasingly accompanied by efforts in revitalized urban areas to restrict the visibility and behavior of the home-

less. When shelter and other resources seem abundant, housed citizens are often frustrated with the refusal of some highly visible homeless to utilize local service programs and perhaps as a result, increasingly support more punitive policies that criminalize activities such as sleeping or panhandling in public places. But whether such methods will lead to greater service utilization and improved outcomes seems dubious.

Homeless policy appears to be at a crossroads. We can continue to improve the availability and mix of service programs, and develop new ways to encourage the chronic homeless to utilize these services, or we can give up on those reluctant to seek help and try to make them less visible. In addition, we must continue to grapple with the question of whether homeless policies should do more to address the structural determinants of homelessness—housing affordability and supply, employment and income opportunities for vulnerable segments of the population, and institutional release policies[1] to name a few—which many claim lead to both new and repeated episodes of homelessness. Or perhaps issues of housing affordability are best left to nontargeted policies—those eligible to all poor households, not just the homeless. The potential responses are many, but the current environment of economic prosperity and budget surpluses provides the ideal setting for expanded and innovative efforts to address this old social problem. We now have not only a wealth of information about the homeless population and their needs, but a growing body of research on the effectiveness of alternative solutions.

The purpose of this brief is to summarize much of the current body of literature pertaining to the national homeless population, with a particular focus on urban homelessness. The brief is divided into two main sections: the first pertains to the homeless themselves (counts and characteristics) and the causes of homelessness; the second reviews the policy and other responses to homelessness.

## Section II: Homeless Counts, Surveys of Personal Attributes, Causal Theories of Homelessness

The increased visibility and size of the homeless population during the 1980s motivated media coverage, public concern, and advocacy on behalf of the homeless. As local and federal governments began to respond to the issue, many studies attempted to count and describe homeless populations. Such research was deemed necessary to inform and

[1]Includes individuals released from mental health facilities, jails or prisons, and foster care programs.

guide public policy and ensure that newly available funding provided the services and programs most in need. Though homelessness seems to have faded as a major issue, researchers continue to document the number and characteristics of the homeless, as well as the trends over time. This section briefly summarizes the findings of this literature, as well as the lessons learned from earlier research. Though many local studies provide quite detailed information on diverse homeless populations in cities or counties, the focus here is on national studies. A discussion of the theories regarding the causes of homelessness ensues.

## Counts

As homelessness gained prominence as a public concern and policy issue, interest emerged in trying to fix the magnitude of the homeless population. The first estimate of two to three million homeless individuals nationwide was offered up in the early eighties by a homeless advocacy group, the Community for Creative Nonviolence (CCNV) (Hewitt 1996). Though their methodology consisted of rough extrapolation from local experts in only the nation's largest cities, the media quickly accepted this estimate as authoritative (Link et al. 1995). Once federal funding became available through the McKinney Act (1987), localities had strong incentive to document (and perhaps exaggerate) their need for shelter beds and services by conducting local enumeration. Formal homeless enumeration, both national and local in scale, has always produced estimates much smaller than the estimates of service providers, homeless advocates and local officials (Wright et al. 1998; Burt 1999).

Despite the development of sophisticated methodologies, difficulties inherent in homeless enumeration render nearly all counts open to criticism. National estimates of the number of homeless have generally extrapolated from urban data to the nation as a whole (Link et al. 1995). Variations in the definition of who is homeless, the time interval chosen, and the characteristics of the homeless themselves go a long way in explaining the difference among estimates of the number of homeless, but substantial uncertainty persists.

### *Challenges to Enumeration*

The initial challenge in enumerating the homeless is determining how to define who is homeless and hence who will be enumerated. Generally homeless counts focus on those utilizing shelter facilities and soup kitchens, as well as those sleeping outdoors on a given day or evening, often referred to as the "visible" or "literal" homeless (Jencks 1994, 7). It is now widely accepted that a large number of the homeless are "hidden"

or "uncountable" during such enumeration efforts (Wright et al. 1998**,** 37; Straw 1995, 330; Link et al. 1995, 347). Many homeless sleep in places so well hidden or not designated as homeless enumeration sites (e.g., hospitals, unlisted flophouse hotels, crackhouses) that even the most thorough count will not find them. A large number of individuals and families temporarily or otherwise live doubled-up with friends and relatives (the "marginally housed"). Many argue that these too should be counted as homeless. Broadening the definition of who is homeless obviously leads to larger counts.

Furthermore, the duration of the enumeration period interacts with the definition employed. A one-night, or point-prevalence, count can enumerate a good portion of the literal homeless. However, it will miss those who had temporary housing on that given night, perhaps due to a hospital stay, incarceration, or the kindness of a friend or family member, but were homeless at some point before or after the count. Extending the period of enumeration to a week, month, or year will take in both the literal homeless as well as the marginally housed and other episodically homeless. Extending the enumeration period effectively broadens the definition of the homeless being counted and increases the estimate. Period prevalence enumeration can be done utilizing shelter databases that track shelter use over long periods of time (Burt 1995). Though they exclude nonshelter users, they are increasingly available in localities and are useful for estimating that portion of the population experiencing homelessness over the course of a year or even longer periods.[2]

One-day or night counts follow the census tradition. Though they tend to overrepresent the chronic homeless, which affects the estimated prevalence of personal disabilities (Snow et al. 1994), these point-prevalent counts avoid duplication in enumerating individuals who utilize multiple services over the course of the period. However, methodologies can be devised to identify those who were counted more than once during multiple-day or longer duration counts. Because enumerators are usually more concerned with undercounting than overcounting, they often employ an extended period of time and coverage of multiple types of service facilities.

Among the more visible and countable homeless, those in shelters have proven much easier to enumerate than those sleeping on the streets, particularly those not accessing food and other services. Experienced enumerators can generally obtain highly accurate counts of the sheltered homeless but there is a great deal of uncertainty or unreliability in street counts (Wright et al. 1998). Part of this difficulty stems from intentional

[2]For an example of shelter-tracking database utilization, please see Culhane (1994).

avoidance of enumerators by homeless who wish to remain hidden. The location of sleeping sites, both outdoors and in abandoned buildings, are often kept confidential by the homeless themselves and outreach workers who visit them to provide services, to protect the safety and privacy of the unsheltered homeless, as well as avoid removal by the police. In addition, unsheltered homeless individuals tend to be mobile during the course of an evening and are especially prone to avoiding strangers out of fear for their own safety, and are thus often missed by enumerators. The hesitancy of enumerators to approach potentially homeless individuals, as well as their uncertainty in determining who is actually homeless, also contribute to undercounting. These difficulties and many others, well documented during national and local enumerations, have been discussed by a number of researchers.[3] Some of these obstacles have been overcome by hiring former/current homeless as well as experienced outreach workers to conduct outdoor enumeration.

The purpose of the enumeration and how the estimate will be used determine the actual definition and methodology employed in a given study. As Martha Burt explained, "If we want to know how many shelter beds are needed to accommodate the homeless population, the relevant count is 'number on an average night,' or perhaps, 'maximum number on a single night.' If, however, we want to know how many housing vouchers it would take to ensure that no more people were homeless, the relevant count would be the total number of households, unduplicated over a period of one or more years" (Burt 1995, 334). In other words, how the findings will be used guides whether researchers employ a one-night count of the literal homeless or a broader one-year prevalence estimate of homelessness. However, even with a clearly defined purpose and well-designed methodology, these definitional quandaries and methodological challenges have repeatedly provided advocates with the grounds for portraying formal estimates as undercounts. The tradeoffs that result (in resources utilized, time spent, and amount of information obtained) when resolving these quandaries affect the perceived adequacy of the count (Straw 1995). As a result, most efforts to count the homeless now deny that they are attempting a literal enumeration of the population, or state that their estimate should be viewed as a lower bound for the actual homeless population size (Wright et al. 1998).

*National Estimates*

The Department of Housing and Urban Development (HUD) attempted the first federal enumeration in 1984. The methodology consisted of both shelter bed counts (in 60 randomly selected metropolitan

[3]See, for example, Rossi (1989) and Wright et al. (1998).

areas) and a survey of local experts to elicit their estimate of each city's homeless population. They employed four different methods of projecting these findings to the nation as a whole and obtained a most likely range of 250,000 to 350,000 individuals on a given night (Hewitt 1996). Shortly thereafter (1987), the Urban Institute conducted a survey of shelter and soup kitchen users in 178 cities with populations exceeding 100,000. They estimated that between 500,000 and 600,000 individuals were homeless over the course of a week. Projecting these figures over the course of the year, they estimated that 1.4 to 1.8 million Americans were homeless over the course of the year (Wolf 2000). Their numbers were much higher than the HUD estimate but still smaller than the two to three million put forward by the advocates.

About the time of the 1990 census a number of local counts contributed significant methodological innovations for homeless enumeration. Peter Rossi was the first to employ a sophisticated stratified probability sampling methodology in his 1989 Chicago study. His methodology involved the assignment of each Chicago block to a category based on the probability (low, medium, high) of finding homeless people on a given night. Enumeration was then conducted employing stratified probability sampling. Those counted were then weighted by the probability of their particular block of location being selected as well as the total number of blocks included in its probability 1987 (Burt 1999). His methodology was subsequently utilized by researchers elsewhere. Because a national Urban Institute study, funded by the Department of Agriculture, was particularly interested in access to food, enumeration sites for the first time included soup kitchens in addition to shelters. As a result, the "study achieved a reasonably high degree of coverage of that part of the homeless population that did not use shelters, without having to conduct searches of street locations at odd hours of the night" (Burt 1999, 269). Bray, Dennis, and Lambert (of the Research Triangle Institute) were the first to combine these methodologies—the block probability method for outdoor enumeration, shelter count, and soup kitchen sampling—while enumerating the homeless population of Washington, D.C. (Burt 1999). As a result, the team reported that shelter enumeration "would capture only 56 percent of the homeless, but that going to both shelters and soup kitchens would provide better than 90 percent coverage" of the "countable" or "literal" homeless. This suggested that research funds were better spent on more reliable shelter and soup kitchen counts than on costly outdoor enumeration. Their study also found that the tendency of homeless individuals to utilize services from more than one program on a given day explained some of the discrepancies between advocate estimates and formal enumeration (Burt 1999).

Planned too early to incorporate these methodological findings, the U.S. Bureau of the Census conducted 1990 "S-Night," a one night shelter and street count in every jurisdiction. The census actual head-count[4] of nearly 229,000 homeless individuals nationwide (about 179,000 in shelters and 50,000 on the street), was about half to a third of the estimates in circulation at the time. Despite the caveat that this number "was not intended to, and did not, produce a count of the homeless population of the country," the census estimate elicited tremendous controversy and attack. Indeed, much of the opposition came before the count even took place, with advocates demonstrating in the nation's capital and urging homeless people not to participate in a count that would clearly understate the size and needs of the population (Wright et al. 1998). According to HUD and the Census Bureau, the census counts are only one factor used to determine funding allocation for homeless programs and, for the most part, the homeless count is not treated separately from the overall census count (Nelson and Kondo 2000). In other words, the bureau's homeless count should not be viewed as an estimate of the total homeless population in 1990, but as a best effort to add to the total count of U.S. residents as many of those individuals not residing in conventional dwellings as possible.

Despite the availability of more scientifically based estimates, the advocates' estimate was the most cited by members of the media and others over the decade. In an examination of media coverage of homelessness between 1981 and 1992, half of the articles cited a national estimate of two million or more, while about a third reported there were 250,000 to 350,000 homeless (Hewitt 1996). In the early nineties, the Congressional Budget Office released a point-prevalence estimate of about 700,000 and other national estimates fell somewhere between one-half and one million individuals (Wright 1989; Burt 1992; Kondratas 1991). Because none of these enumeration efforts came close to the advocates' two to three million estimate, it appeared that their figure was the result of employing the broadest definition of homelessness possible or a purposely elevated estimate adopted in order to garner public support and spur federal involvement (Jencks 1994; Straw 1995; Burt 1999; Shlay and Rossi 1992). Eventually, the advocates themselves adopted one-night estimates in the 500,000 to 600,000 range, retaining their

[4]Because historically the U.S. Census has relied on actual individual or household enumeration, utilization of sampling, extrapolation, and other statistical methodology for the purpose of national counts has proven scientifically and politically controversial. This topic is addressed in detail by Anderson and Feinberg in "Who counts?: The politics of census-taking in contemporary America."

original two to three million as the number of individuals experiencing homelessness over the course of a year (Burt 1995).

*Recent counts*

In March 2000 the Bureau of the Census conducted its second enumeration of the homeless. Though the numbers won't be released till 2001, it was evident from the 2000 census count that the bureau made a significant effort to decrease the degree of undercounting found in the 1990 street count. The bureau added soup kitchens, mobile food programs and day centers to the list of enumeration sites, extended the count period from one night to three days and increased funding of outreach to the homeless and service providers.[5] Locally, a number of cities and counties attempted to employ the homeless or formerly homeless to conduct the street and encampment components of the count, and incentives were offered to increase voluntary participation. It seems likely that the figure they obtain will be considerably higher than the 1990 census estimate due to these definitional and methodological expansions alone. Whether it will approach previous national estimates remains to be seen.

This year, Urban Institute researchers released a new national estimate of the homeless population based on their findings from the 1996 National Survey of Homeless Assistance Providers and Clients (NSHAPC). The survey sampled 76 geographical areas, including rural counties. This data was used to project an estimate of the homeless population on the national level. Burt and Cohen calculated that in 1996 about 445,000 were homeless in the fall and 842,000 were homeless in the winter (Urban Institute 2000). They concluded that nationally over 460,000 individuals were homeless on a given night, over 840,000 during a given week, and between 2.3 and 3.5 million over the course of a year.[6] These findings suggest that regardless of the time interval used, America's experience with homelessness has increased since the mid or late 1980s.

In addition to how many Americans experience homelessness, some researchers have attempted to measure how long people are homeless (Freeman and Hall 1987; Rossi 1989; Burt and Cohen 1990). Shlay and Rossi (1992) review numerous studies and find that while the average length of homelessness was just under two years, the majority of samples had been homeless six months or less. Most recently, the Interagency Council on Homelessness (1999) reported that about 40 percent of surveyed homeless had been homeless six months or less, 31 percent be-

[5]The operation is briefly described in a statement by Kenneth Prewitt, director, U.S. Bureau of the Census to the Subcommittee on the Census, April 5, 2000, http://www.census.gov/dmd/www/4-5-00.html.

[6]http://www.urban.org/housing/homeless/burt_interview.html

**Table 1: National Estimates of the Homeless Population**

| Author | Year | Estimate | Time Interval |
|---|---|---|---|
| National Coalition for the Homeless | Early 1980s | 2-3 million | Unspecified |
| HUD | 1984 | 250,000 – 350,000 | One-night |
| Urban Institute | 1987 | 500,000 – 600 | One-week |
| | | 1.4 – 1.8 million | One-year |
| Census S-Night | 1990 | 229,000 | One-night |
| Urban Institute | 1996 | 460,000 + | One-night |
| | | 842,000 | One-week |
| | | 2.3 – 3.5 million | One-year |

tween six months and two years, 10 percent between two and five years and 20 percent five years or longer. It should be noted that a point-prevalence survey such as the National Survey of Homeless Assistance Providers and the Clients they Serve, is likely to overestimate the average duration of homelessness because of overrepresentation of the chronic homeless (who tend to be homeless longer). It is also true, however, that surveys can underestimate the spells of some homeless because they occur at an early point in what might be a longer spell (Shlay and Rossi 1992).

*Conclusion*

While enumeration efforts have shed some light on the magnitude of the homeless problem, several questions remain. The most recent Urban Institute estimates suggest that homelessness increased between 1987 and 1996, perhaps not surprising given the recession of the early 1990s. But has homelessness continued to increase, despite a robust economy, since 1996? Annual reports by the U.S. Conference of Mayors suggest that indeed homelessness continues to increase, at least in urban areas, and that this increase is reflected in continually increasing demand for emergency services. Their 1998 Report on Homelessness and Hunger reported that 72 percent of surveyed cities reported an increase in the demand for emergency shelter, and that the increase averaged 11 percent (U.S. Conference of Mayors 1998). Likewise, the report for the following year showed an average increase in the request for emergency shelter of 12 percent (U.S. Conference of Mayors 1999). Both surveys reported

that the increased demand for shelter was higher among homeless families (15 percent in 1998 and 17 percent in 1999) than the general homeless population and that nearly all cities surveyed expected these trends to continue into the following year. It would appear that the improved employment prospects and wages of the current boom are more than offset, for the homeless population, by greater tightness in the housing market.

A related question is whether persistent growth in homelessness in America is more a reflection of increased episodic homelessness or chronic homelessness, or both? Comparing the Urban Institute estimates for 1987 and 1996 in Table 1, we see a marked increase in both the one-week and one-year estimates. Using the upper bound estimates, the number of individuals homeless over a week increased 40 percent from 600,000 in 1987 to 842,000 in 1996. Using the lower bound estimates, the number of individuals homeless over the course of a year increased about 65 percent from 1.4 million to 2.3 million. Though far from conclusive, these findings suggest that though the number of homeless during a given week has certainly increased, a large part of this increase is driven by the enhanced likelihood of experiencing at least temporary homelessness over a year.

Lastly, what impact has the increased availability of public shelter beds had on the estimates of homeless? Some might believe that at least some of the perceived growth in homelessness is due to an increased ability to count them today compared to in the past. If more or a larger share of the homeless are now in public shelters, where enumeration is easier then at street locations, comparing current counts with past counts could overestimate the growth in homelessness. This is another issue that could benefit from further exploration.

One thing appears certain, given that the duration of homelessness for some individuals extends over many years, and that new individuals become homeless every year, the problem of homelessness promises to be, or continue to be, a “permanent and long-term part of the U.S. metropolitan landscape” (Shlay and Rossi 1992, 142).

## Personal Attributes

When discussing the characteristics of the homeless population, researchers often speak of the “old” and “new” homeless and the contrast between the two. The “old” homeless of the skid row era are described as a fairly homogenous group with a typical member being an older, single, alcoholic male (Hoch and Slayton 1989). Most agree that today the homeless are a heterogeneous group, on average younger and much more

likely to be female or a member of a minority group than in the past (Snow et al. 1994; Wolch and Akita 1989; Bassuk and Rubin 1987). Despite their diversity, nearly all homeless tend to share three characteristics: they are extremely poor (incomes less than half the federal poverty line), they exhibit high rates of personal disabilities, and they show a tendency to be socially estranged. Since the 1980s, a multitude of surveys has been conducted to detail the characteristics and needs of homeless individuals. While it is possible to summarize the characteristics of the national homeless population, it should be noted that characteristic profiles vary from region to region and locality to locality.

Perhaps the most comprehensive and current data on homeless Americans is provided by the 1996 National Survey of Homeless Assistance Providers and Clients (NSHAPC) sponsored by the Interagency Council on Homelessness (1999). The NSHAPC updates the national Urban Institute survey of 1987 and expands that effort by sampling homeless individuals in suburban and rural areas in addition to central cities. However, because the survey was program-based, those who never or rarely utilize shelters and other service programs are underrepresented. (This may or may not compensate for the fact that a point-prevalence survey such as this one overrepresents the chronic homeless and underrepresent the episodic homeless whose characteristics may vary considerably.)[7] The following characteristic data derives from that survey unless noted.

*Basic Demographics*

One aspect of the homeless population that has particularly interested researchers and the general public has been family structure and the share of the total homeless population made up of families with children. Statistics on family homelessness are affected by whether the household or the individual is the unit of analysis. Fifteen percent of adult homeless households are families, with an average of 2.2 children each; the remaining 85 percent are single adult households. If one counts homeless family members individually, 34 percent of homeless people in the NSHAPC sample were members of a homeless family, while 66 percent were single individuals. Of the 34 percent, 23 percent are minor children, 11 percent their parents. Though 60 percent of homeless women and 41 percent of homeless men have minor children, only 28 percent of these children live with their homeless parent. Of homeless clients in family households, 41 percent have never been married. It is worth noting here,

[7]Martha Burt points out in a *NY Times* article (12/8/99) that the chronically homeless are more likely to be mentally ill or substance abusing than the episodic homeless who are homeless more so for economic reasons.

that these findings are consistent with earlier findings by Shlay and Rossi (1992) who also find that families and children make up about a third of the homeless across the nation. These figures contrast however with two other studies cited by Shlay and Rossi—one by the U.S. Conference of Mayors and one by HUD, both in the late eighties. These studies found that homeless family members made up half of the total population, and their proportion grew from 21 percent to 40 percent between 1984 and 1988, respectively (Reyes and Waxman 1987; U.S. Department of Housing and Urban Development 1989). For the most part, Shlay and Rossi explain those other findings with the fact that those earlier studies concentrated on shelter populations, not street homeless, and therefore overrepresent homeless families (who are more likely to use shelters than single homeless individuals) (Shlay and Rossi 1992).

Males are considerably overrepresented in comparison to the general U.S. population. Sixty-eight percent of the homeless population were male compared to 48 percent among the general population. Among homeless family households, women make up 84 percent of the parents and males only 16 percent, but among single households, the vast majority, 77 percent, are male. This differential is most likely caused by a combination of factors including the concentration of most homeless in urban areas, which tend to exhibit higher rates of female-headed families and poverty (Wright et al. 1998).

Researchers have emphasized that patterns of race and ethnicity vary greatly on the local level and generally reflect regional demographic and poverty trends (Wright et al. 1998; Baum and Burnes 1993).

But that racial and ethnic minorities are overrepresented among the homeless has been well established (Wright and Hall 1987; Freeman and Lam 1987; First, Roth, and Arewa 1988; Wright and Weber 1987; Burt and Cohen 1989). NSHAPC found that homeless individuals were much more likely to be nonwhite; 59 percent versus 25 percent for the nation as a whole. Among the homeless: white non-Hispanic make up 41 percent; Black non-Hispanic another 40 percent; Hispanic 11 percent; American Indians eight percent and other races one percent. black non-Hispanics are especially overrepresented among the homeless (40 percent vs. 11 percent for the nation as a whole).

NSHAPC data on the age of homeless adults are consistent with other literature. Wright et al. (1998) report that the average age of the homeless is low to mid-thirties with five percent or fewer being 65 years of age or older. Among currently homeless adults in the NSHAPC sample, only two percent were elderly (compared with 17 percent in the general U.S. population). The majority (63 percent) were 25 to 44 years of age. Among homeless children, 20 percent were ages zero to two, 22 percent were ages three to five, 20 percent were six to eight and 33 per-

cent were ages nine to 17 (ages were not available for five percent of children in the sample). The age structure of the homeless population is most likely a result of demographic and policy factors. The chronic homeless have lower life expectancy on average. If they survive to the age of 65, they are generally eligible for public programs such as SSI and Medicaid (Rossi and Wright 1987). In addition, some theorize that the homeless are concentrated among relatively younger ages because of the impact of the postwar baby boom generation. Wright et al. (1998) suggest that just as this large cohort have overwhelmed many institutions (such as educational institutions, and the job market) as it aged, it may have also added to the number of the less educated and unskilled who were more vulnerable to homelessness, perhaps explaining some of the rapid expansion in the homeless in the 1980s.[8] Because most of these baby boomers are between 30 and 50, the average age of the homeless would be weighted away from the oldest of the homeless.

A third of currently homeless male clients are veterans, about the same rate of veteran status exhibited among the general male population in the nation. Nearly all homeless veterans are men (98 percent); about half served during the Vietnam era.

*Personal Disabilities*

Funding available through federal research institutes since the mid-eighties enabled researchers to examine the extent to which the homeless experience personal disabilities such as mental illness, substance abuse, and drug problems (Snow et al. 1994). Though data on the prevalence of personal disabilities is essential for the planning of treatment services, there are a number of concerns regarding the estimates of such disabilities among the homeless. These include the variation in definitions and methods used to measure mental illness and substance abuse, the over-representation of the chronically homeless in point-prevalence surveys and a lack of recognition that personal disabilities often represent survival strategies for dealing with the horror of the homeless experience (Shlay and Rossi 1992; Snow et al. 1994). Particularly the variation in survey methodology can lead to considerable variation in the estimates of personal disabilities across space and time. Wright et al. (1998) cite a number of studies in reporting that nationally, about a third of all homeless are mentally ill, 40 to 50 percent abuse alcohol, and 15 to 30 percent abuse drugs other than alcohol (Institute of Medicine 1988; Tessler and

[8]Baum and Burnes (1993) also tie the increase in homelessness to the baby boom phenomenon but through the exposure of a large cohort to behavior disorders (substance abuse, drug addiction) and mental illness. Please see the section on causal theories below.

Dennis 1989; Wright and Weber 1987; Koegel and Burnham 1987). Local studies suggest that rates of drug use can be much higher (Cuomo 1992; Jencks 1994).

The NSHAPC findings fall within range of these estimates. Thirty-nine percent reported having had a mental health problem, 38 percent an alcohol problem, and 26 percent a drug problem, over the past month. Thirty-four percent of the currently homeless did not report any of these problems in the past month. When extending the time period from the past month to the past year, the percent of the currently homeless who report having had a mental health problem increases to 45 percent; an alcohol problem to 46 percent; and a drug problem to 38 percent. About three-quarters of the currently homeless population experienced at least one of these three types of problems within the previous year, 26 percent reported none of these problems. Among those reporting drug use, marijuana was the most commonly reported drug followed by crack cocaine, powdered cocaine, and stimulants. Over the course of their lifetime, 86 percent reported having experienced at least one of these problems (each type being reported by about 60 percent of the total population of currently homeless), only 14 percent had never experienced one of these problems.

*Health*

The health status of homeless populations has been a long-standing public concern. The physical conditions and daily stress under which they live render the homeless extremely vulnerable to both acute and chronic health problems (Wright et al. 1998). In addition, preventive care and follow up to emergency treatment are often made difficult, if not impossible, by the lack of health insurance, lack of financial resources or transportation, and other hardships experienced by the homeless. As a result, the homeless exhibit rates of both chronic and acute health disorders much higher than among the general public. This has been well documented by the findings of the National Health Care for Homeless (HCH) initiative between 1985 and 1987 as well as the 1987 Urban Institute survey of shelters and soup kitchens (Wright and Weber 1987; Burt and Cohen 1989b). The 1996 NSHAPC adds to these earlier findings.

- Access to care & treatment—According to the NSHAPC, 55 percent of the currently homeless population did not have medical insurance but 30 percent were covered by Medicaid. Twenty-four percent reported that they needed to see a physician, but were not able to do so. Nearly 40 percent reported that they were supposed to be taking at least one prescription drug. The most recent data available on HCH patients indicates that insurance coverage is becoming less common

with 70 percent of the homeless served now without public or private insurance.[9]

- Chronic Disorders—Nearly half, or 46 percent of the currently homeless reported having at least one chronic health problem. The most common chronic conditions were arthritis and related disorders, high blood pressure, and some type of physical disability (lost limb, trouble walking, etc.). Though acute conditions can have serious consequences if left unattended, the incidence of chronic disorders among the homeless is especially significant because of its relation to long-term disability and inability to work or engage in other activities necessary to maintaining one's livelihood.[10]
- Acute Disorders—Twenty-six percent reported having at least one acute infectious condition. The most commonly reported category of acute conditions included chest/upper respiratory infection, bronchitis and cold-related illness.
- Individuals who reported having a mental health, drug, or alcohol problem were more likely (53 percent vs. 33 percent) to report at least one chronic health condition.
- Infectious and Communicable Disease—Among the currently homeless, only three percent reported having Tuberculosis (TB), one percent AIDS and two percent other sexually transmitted disease. Because it is common for many not to have been tested for these diseases, or to be unwilling to admit having them, findings from the HCH initiative are perhaps more reliable. In that study, about 968 cases per 100,000 homeless tested positive for TB (about one percent) and 230 per 100,000 reported they had AIDS (about .2 percent) (Wright and Weber 1987). Of the total adult homeless population, three percent had contracted a sexually transmitted disease other than HIV/AIDS (two percent of men, five percent of women) (Wright and Weber 1987).

In addition to differences between the HCH findings and the recent NSHAPC data concerning infectious and communicable disease, there were other discrepancies. For example, the most common acute ailment among the HCH sample was upper respiratory infection (33 percent) but it was followed closely by trauma injuries (25 percent), which were not reported in the NSHAPC data (Wright and Weber 1987). High rates of trauma are not surprising given the rate of victimization (rape, robbery, and assault) to which the homeless, especially homeless women, are be-

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[9]From the HCH website at www.bphc.hrsa.dhhs.gov/hch/hch1.htm.

[10]It might also be interesting to know what percentage of the homeless population experience no health disorders, acute infectious, acute noninfectious or chronic, but that figure was not available in the published NSHAPC data.

lieved to be subject. Twenty-nine percent of the NSHAPC sample reported having been physically or sexually assaulted while homeless. Minor acute ailments such as skin infections are reported by only seven percent of the NSHAPC sample, but by 15 percent in the HCH data. As with TB and other infectious/communicable disease, the rates found in the HCH sample are probably higher because they were obtained by health care professionals reviewing actual treatment records rather than conditions self-reported by the homeless to survey takers.

Though the nutritional profiles of the homeless have received less research attention than health disorders, it is an important topic because prolonged malnutrition can contribute to chronic disorders such as anemia and degenerative bone disease. Malnutrition can also render an individual more vulnerable to infectious and communicable disorders (Wright et al. 1998). In the NSHAPC sample of currently homeless, 28 percent reported that they sometimes or often did not get enough to eat, and 20 percent report eating only one meal a day or less. It is unclear whether the nutritional situation of the homeless has improved since 1996. In their annual Status Report on Hunger and Homelessness in America's Cities, the U.S. Conference of Mayors reported that hunger has continued to grow in urban areas. From 1997 to 1998, 78 percent of the cities surveyed registered an average increase of 14 percent in the request for emergency food assistance, 21 percent of such requests were estimated to have gone unmet. Things were worse in 1999 when 85 percent of the cities surveyed reported an average increase of 18 percent in the requests for food assistance, and again, 21 percent of these requests went unmet. Yet comparing the 1996 NSHAPC to the 1987 Urban Institute data, it appears that the availability of food has increased. The homeless in 1996 were less likely to say they sometimes or often got too little to eat (28 percent vs. 38 percent in 1987) and were more likely to get enough of what they wanted to eat (31 percent vs. 19 percent).

*Education, Employment, and Income*

If personal disability profiles provide some idea of the barriers to employment and self-sufficiency homeless individuals face, education and work experience characteristics provide some insight to the tools that they have at their disposal. In the 1996 NSHAPC sample, 62 percent of the currently homeless had a high school diploma, GED, or some higher degree. Forty-four percent had worked in the past 30 days, though most (32 percent) were doing temporary work expected to last three months or less. Only 13 percent worked at a job that they had had for three months or more with the same employer. Of the 56 percent who did not work in the last 30 days, most said they wanted a regular job. If they were not actively searching for employment, the most commonly cited reason was

ill health or physical disability. Another possible barrier to employment is having a record of incarceration. About half (49 percent) of the homeless surveyed reported having been incarcerated for five days or more in a city or county jail, and 18 percent had been in a state or federal prison at some time in their life.

Data pertaining to monthly income confirm that the homeless are the very poorest of the nation's poor. Median income, from all sources, was $300 a month, 67 percent had incomes less than $500 a month. The mean income of a single homeless client was $348 a month, about half of the 1996 federal poverty level for a single person. Homeless family households reported a mean income of $475, which is just under half the federal poverty level for a family of three in 1996. Work was the most commonly reported source of income (49 percent of the total homeless sample). Forty-five percent said they were currently receiving some type of means-tested benefit, including food stamps. Lifetime receipt of such benefits was much higher (81 percent) suggesting that for some reason, a large number of the homeless were no longer receiving means-tested assistance. Though nearly all should have been eligible, only 52 percent of homeless families received Aid to Families with Dependent Children. Only 21 percent of all homeless reported that they received some financial help from friends or family members. Eight percent of the homeless reported some income from panhandling in the previous 30 days.

*Length of Homelessness and Current Places of Shelter*

Among those currently homeless in 1996, half were experiencing their first episode of homelessness, 34 percent had been homeless three or more times. Just over half (54 percent) had been homeless for a year or less (39 percent for less than six months). Twenty percent of those currently homeless had been homeless for five years or more. The majority (63 percent) of all homeless were currently residing in emergency or transitional shelter of some kind and 18 percent were sleeping outdoors or in places not meant for overnight use (bus stations, abandoned buildings, etc.). Thirteen percent were staying as a guest in a house, apartment or room, most likely temporary situations. The remaining six percent were in "pay-yourself" hotels, motels, or dormitory hotels, or some "other" place.

*Rural Homelessness*

Most national surveys, such as the 1987 Urban Institute study, only examine homeless populations in large metropolitan areas, perhaps owing to the high concentration of homeless located there. But urban homeless populations differ significantly from the rural homeless and these differences must be taken into account when determining service

needs and provision. Among those currently homeless in the NSHAPC study, 71 percent were located in central cities with an additional 21 percent in the "suburban/urban fringe." Only nine percent were located in rural areas. This conflicts with a 1996 estimate by Fantasia and Isserman (1996), which reported that 18 percent of the homeless lived in rural areas. Part of this discrepancy could be due to differences in how "rural" is defined—some of Fantasia and Isserman's rural homeless might be contained in the NSHAPC's suburban/urban fringe population. Furthermore, estimates of the size of the rural homeless population may differ because the rural homeless are harder to count. There are fewer shelters and other programs available in rural areas and enumeration efforts are generally program-based so conducting accurate counts is a greater challenge. Nevertheless, the addition of nonurban areas to the sampling frame used in the NSHAPC allows for a comparison of the homeless populations in central city and rural areas (though the sample size for the rural population is much smaller).

Relative to urban areas, homeless individuals in rural areas are more likely to be white (42 percent vs. 37 percent) and much more likely to be American Indian (41 percent vs. 5 percent). They are also much less likely to be African American (9 percent vs. 46 percent). The rural homeless population also seemed to be less concentrated in the younger age groups (24 percent were under 35 years of age vs. 38 percent among central city homeless) and were less likely to have a high school diploma/GED or higher degree (36 percent vs. 64 percent). They were however, more likely to have ever been married (64 percent vs. 49 percent in central cities) and to be currently married (7 percent vs. 4 percent). Rural homeless were more likely to report having had problems with alcohol in the past month (48 percent vs. 39 percent) but less likely to report problems with drugs (15 percent vs. 28 percent) and mental health (26 percent vs. 41 percent). Acute health conditions were reported at about the same rate for both the rural homeless and their central city counterparts but having one or more chronic conditions was reported by far fewer rural homeless (33 percent vs. 48 percent). The rate of uninsurance was also higher in rural areas (63 percent vs. 55 percent). The rural homeless had a higher monthly median income ($475) than central city homeless ($250) and were more likely to have worked in the past 30 days (though the vast majority of work was still temporary in nature).

*Conclusion*

As with national enumeration and changes over time in the size of the homeless population, trends in the characteristics of the homeless are meaningful in that they help guide the appropriate policy response. Though limited to the central city homeless population, comparison of

the 1996 NSHAPC data to the 1987 Urban Institute data permits identification of some of these changes over that decade. First, the homeless today are more likely to be African American (46 percent vs. 41 percent in 1987), to have completed high school (32 percent vs. 29 percent), and to have more than a high school diploma (27 percent vs. 20 percent). Monthly average income was higher ($267, adjusted for inflation vs. $189 in 1987), perhaps at least partially reflecting the greater receipt of government benefits in 1996.

Though comparisons were not made with regard to the duration of homelessness or the number of episodes experienced, the period-prevalence estimate, 2.3 to 3.5 million Americans homeless over the course of the year, released shortly after the NSHAPC report,[11] supports assertions that "most homelessness 'these days' is of the episodic rather than chronic variety" (Wright et al. 1998, 15; Wright and Weber 1987; Sosin, Piliavin, and Westerfelt 1990). As discussed in further detail below, such findings have implications for planning not only emergency shelter and services for those currently homeless, but to the extent that we can single out first-time or episodic homeless, they have the potential to guide preventive policies to break the cycle of residential instability and avoid future homelessness.

## Causes

Historically, attempts to explain why people were homeless focused on economic marginality and individual disability, and the remedies provided reflected an ideology that, especially among the able-bodied, homelessness was a lifestyle choice (Schutt and Garrett 1992). Though few today would deny that the homeless are disproportionately affected by personal disabilities, poverty, and unemployment, the exact relationship between homeless characteristics and the causes of homelessness is widely disputed. Eager to explain the rapid growth in homelessness during the 1970s and 1980s, a number of researchers began exploring various causal theories of homelessness. Today these theories generally fall into one of two categories: (1) individual deficits or personal disabilities, or (2) societal or structural conditions. Individual factors include mental illness, behavioral problems including substance abuse and addiction, and family estrangement; factors that affect one on a deeply personal or intimate level. Structural factors incorporate those larger economic or societal conditions such as the changing job market; increasing poverty

[11]Discussed above in the enumeration section. This period-prevalence estimate was based on the NSHAPC data.

and a widening income gap; and changes in the housing market. This latter category has been described as relating to the "way our society's resources are organized and distributed" (Wright et al. 1998, 25). Adding to this are the affects of demographic trends and public policies. These are often included with the structural factors, but because they tend to interact with both categories of factors, they will be discussed here where they seem relevant.

The objective here is to summarize the most recent literature on causal theories of homelessness. While not exhaustive, the following pages describe the causal factors most commonly cited by researchers and advocates. Though no attempt is made to prove or disprove the various theories, some arguments in support or opposition are presented. A number of researchers have examined the various factors theorized to cause homelessness and the following pages borrow heavily from their work. Among them are Wright, Rubin, and Devine (1998); O'Flaherty (1996); Koegel, Burnam and Baumohl (1996); Jencks (1994); Baum and Burnes (1993); and Burt (1992).

*Individual Factors*

Those who emphasize individual factors generally argue that homelessness is ultimately a personal disabilities issue because even if affordable housing were abundant, the nature of their disabilities render many of the homeless (particularly the chronic homeless) unable to maintain such housing in the long-term. Not only is their capacity to earn income and live independently severely limited, but government policies have failed to provide adequate support and treatment to assist them, or their families, in achieving these ends. As a result, individuals with one or more debilitating disorders often find themselves in a cycle of homelessness, temporary treatment and incarceration. Alice Baum and Donald Burnes (1993) present this detailed argument in *A Nation in Denial: The Truth About Homelessness*. They suggest that the failure of Americans to admit that individual disabilities are the primary reasons for homelessness has led to ineffective public policies.

One way to analyze causal theories of homelessness is to examine whether possible causal factors changed in recent decades in a way that could account for the significant rise in homeless over the 1970s and 1980s. Burt (1992) argued that if individual disabilities are to be associated with growing homelessness, we would expect to see increasing rates of mental illness and substance abuse both in the general public and in the homeless populations. But in fact, rates for these disorders have remained fairly constant over time, and illicit drug use even declined (Burt 1992). Since an increase in the rates of these disabilities is not evident, some conclude that other factors were accountable for the increase in

homelessness. One exception is made with regard to the advent of crack in the 1980s. It is believed that the availability of this cheaper form of cocaine did lead to some increase in drug use and homelessness, at least in urban areas (Jencks 1994). Unlike patterns exhibited with illicit drugs in general, emergency episodes involving the use of cocaine increased steadily throughout the 1980s (Burt 1992) and some believe cocaine use was partially responsible for the increase in homeless families (Baum and Burnes 1993).

Even if rates of mental illness or substance abuse among the general population have not increased, demographic trends combined with constant rates of these disorders could still increase the number of Americans in need of treatment. Baum and Burnes posit that the maturing baby boom generation added about 20 million Americans to the ranks of those at risk of mental illness and substance abuse between 1970 and 1980 (Baum and Burnes 1993). This growing number of individuals in need of treatment services found themselves in communities lacking such supports as a result of changing social policies.

Treatment of those with substance abuse issues or mental illness has changed over time, and it is possible that these shifts have had some impact on the homeless. Both the decriminalization of alcoholics and deinstitutionalization of the mentally ill were motivated by benevolent intentions. The decriminalization of alcoholism was a shift from viewing alcoholics as morally deficient to victims of an addictive disorder in need of help not punishment. Treatment of alcoholics shifted from sheltering them in "drunk tanks" or jails to letting them deal with their illness on their own terms while in the community (Rossi 1989; Shlay and Rossi 1992; Baum and Burnes 1993). For many, because the need for treatment services has always outstripped the availability of such services and obtaining shelter when drunk is difficult, this has meant increased homelessness. Deinstitutionalization was inspired by a sincere belief that state hospitals did not provide adequate care and that optimal treatment could be best delivered in a community-based outpatient setting. Following a similar pattern, the deinstitutionalization of the mentally ill released most patients at state-run mental hospitals to their communities, without providing for adequate mental health services on the local level. This movement proceeded in rather distinct phases (Jencks 1994), the first of which began in the late 1940s and early 1950s as psychiatrists began shifting to outpatient treatment made possible by the advent of new drugs. Creation of Medicare and Medicaid in the mid 1960s created an incentive to move inpatients in state facilities to nursing homes and other care settings subsidized by federal funds (O'Flaherty 1996; Blau 1992). In the late 1970s changes in state laws regarding involuntary commitment allowed for those to be involuntarily institutionalized only if they

posed a danger to themselves or others. As a result, between 1955 and 1990 the number of patients in state psychiatric facilities fell from over 500,000 to about 90,000 (O'Flaherty 1996).

As envisioned, deinstitutionalization would entail establishing a network of local outpatient services and programs, but it fell far short of this goal. Though 2,000 community mental health facilities were supposed to be opened, only 789 materialized (Schutt and Garrett 1992). Overall, the established outpatient services fell short of what was previously provided by state facilities, and priority was given to the treatment of the easier to serve and less dysfunctional mentally ill (Lomas 1992). Part of this failure to provide adequate services has been attributed to efforts in the 1980s to save money and scale back government programs. (Jencks 1994). Others have suggested that because funding responsibilities were shifted to the federal government (via Medicaid, Medicare and SSI), states and localities became lax in ensuring that individuals were helped in a continuous and cost-effective way (Torrey 1991). The result was wide-scale neglect by the public sector of those most in need of treatment services (Jencks 1994). Without proper treatment and support, it is extremely difficult if not impossible for individuals with disabilities to maintain a self-sufficient lifestyle.

That deinstitutionalization did not proceed as intended is clear, but how much of an impact the movement had on rates of homelessness is debatable. If the process of deinstitutionalization contributed directly to homelessness, we would have expected to see increases in the homeless population during earlier phases of the movement, rather than just the dramatic increase visible in the late 1970s and early 1980s. In fact, the largest movement of patients out of mental institutions occurred prior to 1975 and the vast majority did not end up on the street (O'Flaherty 1996; Blau 1992). That a lag occurred between the early intensive phases of deinstitutionalization and the appearance of former patients suggests to some that other factors were at play in causing homelessness (Hamberg and Hopper 1992). After 1970, many of those released from institutions were transferred to nursing homes rather than just released to the community so that by 1977 half of the nation's 1.3 million nursing home residents had a mental disorder (Blau 1992). Others have documented that a large number of the deinstitutionalized, or those who would be institutionalized today under pre-1950s policies, are now in state prisons rather than in more appropriate care settings. (Raphael 2000; Torrey 1997; Dear and Wolch 1987). In other words, jails, prisons, and nursing homes have become substitutes for state psychiatric facilities. These facts support the possibility that the impact of deinstitutionalization on homelessness, to the extent that there was one, was by way of its interaction with other factors, such as the loss of cheap single-room occupancy units

and public assistance levels not adequate to cover the costs of available housing (discussed below).

Though not as often mentioned as a causal factor, chronic health disorders are another type of disability that can in some cases affect the likelihood of becoming homeless. Health Care for the Homeless (HCH) data suggests that "poor physical health" was the major reason for the homeless condition of three percent of their patients (the tenth most common reason cited) and a "contributing factor" for nearly a quarter of them (Wright et al. 1998, 153; Wright and Weber 1987). But because homelessness also leads to both acute and chronic health problems, physical health problems can affect both the number and duration of homeless episodes experienced. It has been suggested that a major link between homelessness and physical disability, as well as mental illness and substance abuse, is employability. Wright et al. (1998) emphasizes that over half of those for whom poor health was the major cause of homelessness, (the three percent mentioned above), were considered "not employable." In addition, among 17 percent of the total HCH sample who were considered unemployable less than 20 percent received public disability benefits. This once again highlights the role of policy, in this case regarding the determination of public benefits, and suggests that such policy interacts with personal disabilities to increase the risk of homelessness.

In addition to affecting employability, individual disabilities can increase the likelihood of becoming homeless in a number of ways. Many shelters do not accept individuals with current or recent problems with substance abuse or mental health because their staffs are not trained to handle such clients (Jencks 1994). There is also a sense that accepting the least desirable of homeless clients will bring down the quality and perceived safety of a facility, which in turn will deter other less-troubled homeless individuals and families from seeking shelter. In particular, dually diagnosed individuals, those with both substance abuse and mental health disorders, have extremely limited shelter possibilities. Even if sufficient shelter for the severely disabled were available, many of these individuals are not willing to seek assistance or engage in rehabilitation services in exchange for shelter. The virtual abolishment of involuntary commitment means that the severely mentally ill can only be taken into custody when they pose a danger to themselves or others. What now often results is a cycling of the mentally ill homeless between brief periods of hospitalization, most often in a hospital emergency ward, incarceration in local jails, and homelessness (Torrey 1997; *San Francisco Chronicle*, 2000). Substance abusers as well cannot generally be forced to seek shelter or treatment. As a result, poor individuals with one or

more personal disabilities are likely not to just experience homelessness, but to be among the most visible homeless, the unsheltered homeless.

Many researchers stress that homeless individuals are often alienated from their family and friends. Some suggest that this alienation is a result of family members losing patience with the behaviors and needs of their homeless or soon-to-be homeless kin and eventually sever ties. Others suggest that familial estrangement begins during childhood in broken or dysfunctional homes and that a high percentage of homeless individuals share such childhood experiences (Sosin et al. 1990; Susser et al. 1991). Wright et al. (1998) suggest that the high proportion of homeless individuals who were raised by a single-parent or in out-of-home placement supports this notion. Negative experiences in early childhood, possibly a result of where and how one is reared, could lead to psychological damage that in turn leads to an increased risk of homelessness in adulthood (Koegel et al. 1996). Once homeless, individuals are not likely to form healthy and supportive relationships because they tend to associate with other severely disabled people in similar situations. Whether homelessness is more a cause of or result of familial estrangement is not clear, but the effect of such alienation is certainly increased likelihood of becoming homeless and decreased ability to escape that condition.[12]

In conclusion, it seems that though personal disabilities and family estrangement have been present throughout the decades, changes over time have led to decreasing avenues of support and livelihood. In addition to policy changes (such as deinstitutionalization, declining public benefits, and insufficient social services), many researchers point out that the destruction of skid row areas led larger numbers of disabled individuals to become homeless (Marcuse 1988; Jencks 1994). Skid row areas provided an environment in which even severely disabled individuals could sustain themselves. Inexpensive shelter was available in single-room-occupancy (SRO) hotels, cheap or free meals were provided by soup kitchens, and day labor involving minimal education and skills granted the opportunity to earn the money to purchase these basic necessities.[13] Because many researchers felt that these changes were not enough to explain the growth in homelessness over the 1980s, attention was turned to other factors, structural and social factors, in order to close the gap.

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[12]Jencks found little evidence that familial support has decreased significantly between 1980 and 1990 and concluded that familial estrangement, despite its importance in determining individual outcomes, did not play a major role in the growth in homelessness during the 1980s.

[13]The factors that aided in the destruction of skid row areas are most often categorized as structural and therefore discussed in that section.

*Societal/Structural Factors*

Researchers generally agree that personal disabilities and social estrangement disproportionately affect homeless individuals and that these characteristics pose significant challenges to the rehabilitation process and prevention of future homelessness. Most also agree that changing policy over time has resulted in decreased support for the disabled who in the past were primarily cared for in institutionalized settings. But those who examine structural causes of homelessness emphasize that economic and social trends, combined with government policies, have affected the ability of nondisabled individuals to keep themselves housed. For the most part, these structural theories can be summarized in the following way. In recent decades, a number of factors having to do with the employment market, family structure, the distribution of income and public benefits led to an increasing number of poor Americans with limited financial resources to spend on housing. At the same time, factors affecting the housing market prevented the normal adjustment of prices and supply of low-income housing necessary to accommodate the increased demand.

In *Beside the Golden Door: Policy, Politics and the Homeless*, Wright et al. (1998) detail the ways in which poverty has increased in the United States from the 1970s to present day. Though the poverty rate fluctuates with economic cycles, continued growth of the general population has generally caused the actual number of poor people to increase over time. From 1970 to 1988, the number of poor Americans increased 26 percent from 25.4 million to 31.9 million individuals (Koegel et al. 1996). More recently, though the number of poor declined from a high of 39.3 million in 1993 to 36.5 million in 1996, the final figure is still about nine percent higher than the 33.6 million poor in 1990, (Wright et al. 1998) and about 14 percent higher than in 1988. Also emphasized is the growing income gap that has the effect of intensifying the degree of poverty experienced by the poor. In 1970, the bottom fifth of the income distribution received about five percent of the country's income while the top fifth received just over 40 percent. In 1996, the bottom fifth received only four percent (a 22 percent decrease) while the top fifth increased their share of the nation's income to 47 percent (a 14 percent increase) (Wright et al. 1998). In addition, the average income for poor families decreased as a share of the federal poverty level between 1977 and 1992 and a growing share of the poor could be classified as "extremely poor," having incomes below 50 percent of the federal poverty level for their household size (Wright et al. 1998). Lastly, the authors found that poverty became more chronic (increased length of poverty episodes and larger share of total poor who remain poor year after year) and concentrated in urban neighborhoods.

Factors offered as explanations for the growing rate of poverty in the U.S. include transformations in the labor market, demographic trends, and government policies affecting public benefits and taxes. Though it began earlier in the century, "deindustrialization" produced a continued shift from high-paying, often unionized, full-time manufacturing jobs to low-paying part-time or temporary positions throughout the 1970s and 1980s (Koegel et al. 1996). In addition, increasing globalization is believed to have led U.S. companies to keep wages low in order to remain competitive with other nations (Wright et al. 1998). These trends had implications for the wages and job security of low-skilled and poorly educated workers. At the same time, baby boomers began entering the job market creating more intense competition (Wright et al. 1998). Data indicate that real hourly wages fell between 1973 and 1993 for all workers except those above the 80$^{th}$ percentile, falling the most (11.7 percent) for those at the 20$^{th}$ percentile (Hardin 1996). The decline in wages was most severe among blue-collar and service industries, especially for male workers. Jencks gives particular attention to increasing long-term unemployment among working age men during the same time. Between 1969 and 1989, long-term joblessness doubled from five percent to 10 percent (Jencks 1994). Duration of unemployment among homeless persons has also been documented (Rossi 1989; Burt and Cohen 1990).

In addition to changing job opportunities, marital patterns and family structure shifted significantly over the 1970s and 1980s. Individuals increasingly chose to remain unmarried and live alone. Living alone is not said to increase the risk of homelessness per se, but it has been suggested that living alone, to the extent that it indicates limited family ties, can lead to longer episodes of homelessness because there are fewer people with which to pool resources and obtain housing (Jencks 1994). Women increasingly entered the job market, the marriage rate declined, unmarried women were more likely to have children, and the number of families headed by a single mom grew (Jencks 1994). That female-headed families are disproportionately represented among poor households is well documented, and it has been suggested that their elevated rates of poverty subject them to increased risk of homelessness (Wright et al. 1998). Jencks concurs, "It was the fact that unskilled women not only married less but continued to have children that pushed more of them into the streets" (Jencks 1994, 58).

For poor families who relied on public assistance, the deterioration of benefits during the 1980s meant increased economic hardship (Shlay and Rossi 1992). Some have theorized that in order to provide incentives to work, government policies responded to decreasing labor wages by lowering the social wage provided by public benefits (Blau 1992; Hardin 1996). Inflation lowered the real value of public benefits (Elwood and

Summers 1986), and the purchasing power of families receiving public assistance declined nearly a third from $568 in 1970 to $385 in 1984 (Koegel et al. 1996). Moreover, average AFDC and SSI benefits in many states fell short of the income needed to afford available rental units (Newman and Schnare 1988; Rossi 1989). Eligibility for means-tested benefits were also tightened. In 1981, 500,000 AFDC recipients lost their benefits, an additional 300,000 had such benefits reduced, and between 1981 and 1984 (Burt 1992), nearly 500,000 disabled individuals lost their Supplemental Security Income and Social Security Disability Insurance (Hopper and Hamberg 1986).

It has been said that the policies of the eighties resulted in an upward transfer of income (Blau 1992), and the available evidence seems to support this conclusion. The consensus certainly seems to be that trends over the 1970s and 1980s resulted in increased economic instability among poor individuals and families and that a larger impoverished population was left with fewer resources for basic necessities. But many point out that an increasing poor population alone would not have been enough to lead to an increase in homelessness. Normal functioning of the housing market in theory, should lead the supply and price of housing to adjust to the increasing demand by the poor for very cheap housing. Some have suggested that developments on both the national and local levels prevented this normal adjustment from occurring.

According to Jencks, causal theories involving housing emerged shortly after homelessness gained prominence as a national issue. He explains that these theories generally paired the decline of skid row single-resident occupation (SRO) units with single adult homelessness and the shortage of affordable housing with family homelessness. SRO buildings and cubicle hotels common in skid row areas provided inexpensive shelter for single adults in the 1940s and 1950s. Many of these facilities were destroyed in the 1960s and 1970s as demand for SRO units declined but continued to fall later as a result of urban renewal efforts (Bahr 1967; Jencks 1994). In the past decades, over one million SRO units were lost, about half of the total supply of the time (Hartman and Zigas 1989; Wright et al. 1998). The loss of such units, however, was concentrated in urban areas: San Francisco lost 18 percent of its SRO units over fours years in the 1970s; New York lost 60 percent between 1975 and 1981; Los Angeles lost half of its units by 1985; Denver lost two-thirds between 1971 and 1981, and Seattle lost 15,000 units between 1976 to 1984 (Hopper and Hamberg 1986; Rossi 1989; Hoch and Slayton 1989; Wolch and Dear 1993; Koegel et al. 1996).

The decline in other types of affordable housing has been repeatedly documented using different proxies. For example, Wright et al. (1998) present data from some of the largest U.S. cities indicating that the num-

ber of "low-income" units declined from 1.6 million in the early seventies to 1.1 million in the early eighties (a 30 percent decrease) while the number of poor people in those cities increased 36 percent over that same period. Looking specifically at multiroom units across the nation, Apgar et al. (1989) found that between 1981 and 1987 the number of units renting for $500 a month or more increased by 86 percent while those renting for less than $300 decreased by 13 percent. They also noted that the national vacancy rate for units less than $150 a month was 3.8 percent in 1987, while five percent is considered the lower threshold for normal functioning of the housing market. Dolbeare (1996) reports that while there was a surplus of 500,000 affordable (costing less than 30 percent of one's income) units in 1970, by 1989 there were only 2.8 million such units available for 7.8 million renters, a deficit of 5 million units.

The housing that was available became less affordable. Dolbeare (1996) found that from 1970 to 1989, median inflation-adjusted gross rents increased 31 percent from $317 to $416 while the affordable housing cost (30 percent of total income) for a household at the 25$^{th}$ percentile (of the income distribution) fell 30 percent from $240 to $169. In 1993, nearly 70 percent of unsubsidized renters with incomes below the poverty level paid more than half of their total income for housing. As a result, across the nation in 1994, at least one-third of all renter households in each state could not afford the HUD fair market rent (FMR) for a one-bedroom unit and in every state but one, the FMR exceeded the maximum AFDC grant for a family of three. Jencks (1994) offers at least two reasons as to why he is not convinced that rising housing costs resulted in increased homelessness.[14] First, he believes that most of the increase in housing costs during that period were the result of real improvements in quality and that the loss of low-quality units was more a response to increased demand for better housing during earlier prosperous periods. Second, he doubts the verity of self-reported income data with which rent burden statistics are often calculated.

Against this apparent backdrop of increasing poverty and decreasing housing options, many have suggested that government policies failed to alleviate, and in some cases exacerbated the situation. Though HUD's total expenditures on subsidized housing for low-income households continued to grow in the 1970s and 1980s, two trends have had an affect on the affordability and supply of low-income housing available. First, the rate of growth in new rental subsidies has slowed considerably. From 1977 to 1979, HUD added an average of 350,000 new subsidized units a

[14]Jencks does allow that the destruction of skid row and the failure to provide housing for those who were deinstitutionalized did contribute to increased homelessness.

year. A decade later, from 1987 to 1989, the average number of new commitments was 103,000 units.[15] Second, federal funding of low-income housing has shifted from subsidizing new construction to subsidizing households in existing rental units. In 1977, 65 percent of newly subsidized units were in newly constructed buildings. In 1997, 72 percent of new subsidies aided families in existing rental units (Quigley 1999).

While federal housing policy for the poor shifted increasingly to private market provision, changes in the tax code both altered the profitability of different types of housing development and increased the price of rental housing. The 1986 Tax Reform Act altered the treatment of rental housing (in terms of the depreciation schedule), which had the effect of reducing the profitability of rental housing and drove up the rents landlords needed to charge in order to break even (Quigley 1999). Some owners of low-income rental units often found abandonment, arson, or demolition more profitable than maintaining units and renting them out (Wright et al. 1998). Increased tax deductions for home ownership also increased the profitability of owned versus rental housing.

While federal housing subsidies have always played a crucial role in making housing affordable for low-income households, the availability of such subsidies has been and remains extremely limited. Only a fraction of poor renters eligible for housing subsidies receive such assistance and waiting lists for public housing aid, where not already closed, continue to grow (Wright et al. 1998; Quigley 1999). Such facts do lend support to criticism that the federal housing policies have failed to keep pace with the needs of poor Americans.

Efforts to revitalize urban centers and pressures to gentrify older neighborhoods also saw a large number of affordable housing buildings demolished or converted to housing for wealthier renters or homebuyers (Wright and Lam 1987; Hoch and Slayton 1989; Ringheim 1990; Hartman and Zigas 1991; Koegel et al. 1996). Estimates of the number of renters displaced each year due to the destruction of units range from 1.7 to 2.4 million people each year (Huttman 1989; Schutt and Garrett 1992). Efforts to develop new affordable housing, particularly SRO and cubicle type facilities, often ran into local regulations and community opposition. According to Jencks (1994), policies barring the creation of new cubicle hotels and the like had the effect of forcing people into homelessness. Conservative researchers such as William Tucker have argued that local rent control ordinances suppressed the development of additional affordable housing, drove up rental prices, lowered vacancy rates, and contributed significantly to rates of homelessness. Critics of this argument have

[15]Data is from the U.S. House of Representatives Committee on Ways and Means, 1998 Green Book: Table 15-25, as cited by Quigley (1999).

found it to be exaggerated or completely false (Grimes and Chressanthis 1997; Quigley 1990).

It has been argued that the end result of these private housing market trends was a reversal of the trickle down theory of low-income housing (Wright et al. 1998). Rather than upper-income households moving to newly developed neighborhoods and leaving behind older units for lower-income households, many began returning to urban areas and renovating older housing. In addition, new housing developments catered to the growing upper classes who could afford luxury housing more profitable for realtors and developers. The work of Brendan O'Flaherty (1996) tied housing market dynamics with trends in income distribution and poverty. In effect, the growing income inequality resulted in a shrinking middle class, which in turn meant fewer units built for the middle class, and hence a smaller supply of housing for the poor (because there is less to trickle down). This in turn led to increased prices for lower-income housing, even that of the lowest quality. The share of very poor who were forced to choose between abandonment-quality housing at higher prices and homelessness increased, and more individuals ended up homeless.

It has been argued that the increasing availability of new and high quality shelters during the mid- and late-1980s led more people to become homeless. Jencks suggests that the creation of shelters and soup kitchens most likely enables people, particularly single adults, who are doubled up in less than ideal situations to leave those situations for literal homelessness (Jencks 1994). Likewise, family members and friends who have tired of providing assistance might be more likely to deny shelter to someone when they know public shelter is available locally. For families living in situations of domestic violence or experiencing episodes of financial insecurity, shelters provide emergency housing while they transition to self-sufficiency (Koegel et al. 1996). It has been proposed that decreasing stigma associated with homelessness and administrative procedures that tie eligibility for housing subsidies to homelessness provide additional explanations as to why utilization of shelters may have increased in recent decades. As a result of both the increased availability and utilization of shelters and other services, those in need, and those who were previously living doubled-up or marginally housed, have become more visible and countable to the general public (Wright et al. 1998). In other words, increased availability of shelter to some degree shifts people from a state of hidden homelessness to visible homelessness.

*Quantitative Analyses of Causes*

Theories on the causes of homelessness have existed as long as the phenomenon itself but those pertaining to recent homelessness emerged primarily during the 1980s. Researchers, the media, and the general public tend to choose from among them even today when trying to explain the persistent growth in homelessness in the 1990s. Most often, theories were based on the observed correlation between rates or counts of homelessness and trends in housing affordability, poverty, drug use, demographic factors, public assistance, and other social policies, and were thus more associational than causal in nature (Ringheim 1993). Since the late eighties, however, researchers have gone a step further and applied the tools of econometrics to the analysis of the structural determinants of homelessness. These studies generally adopt one of two approaches: modeling the factors that affect the probability of an individual becoming homeless or modeling the factors that may explain the variation in rates of homelessness over space or time (Early 1998).

As recently as 1993 it was suggested that the designing of policies to combat homelessness had been seriously hampered by a "lack of systematic analysis of the causes of homelessness" (Honig and Filer 1993). About this time, a study by Burt (1992) provided one of the earlier efforts to fill this void.[16] Burt used data from 147 primary cities (with populations exceeding 100,000 across the nation to examine the predictive power of structural factors in terms of explaining rates of homelessness. As her dependent variables, Burt employed the rates of homelessness across cities for a specific point in time 1989, and the change in these rates over the 1980s (1981-89). Because the accuracy of homeless counts were as contested then as now, Burt chose as her proxy the number of shelter beds per capita. Explanatory variables included a large variety of proxies for the housing market, population size/characteristics, poverty and income (including employment and education variables), and public benefits. Other variables included the average winter and summer temperatures, drug- and alcohol-related hospital admissions and local revenues and social service expenditures.

Overall, Burt found the variables that tended to increase homelessness to be higher rates of unemployment, higher proportions of single-person households, the absence of General Assistance programs, higher costs of living, and public benefit payments that lag behind the cost of living. The structure of local labor markets was significantly associated with rates of homelessness particularly the percentage of employment in

[16]Two precursors to Burt's work include *Down and Out in America: The Origins of Homelessness* by Peter Rossi (1989) and *At Risk of Homelessness: The Roles of Income and Rent* by Karin Ringheim, (1990).

the retail sector exhibited a negative relationship. Unexpectedly, the poverty rate did not exhibit a significant role and higher levels of public benefits were significantly and positively associated with homelessness. Burt felt the most likely explanation for the latter finding was that higher benefits could be driven by higher costs of living and might still be inadequate to prevent homelessness.

A number of potential problems with the study have been noted, key among them concern over the appropriateness of using bed counts as a proxy for the rate of homelessness. Burt herself discusses this early on and admits that her model better explains homelessness over time (from 1981 to 1989) suggesting that either the explanatory variables become more influential with time, or that the proxy for homelessness becomes more accurate as the number of shelter beds catches up with the need. She acknowledges that the availability of beds is dependent on several factors other than the local demand for them (such as financial resources, neighborhood opposition, political ideology, etc.). That these and other variables are omitted from the model has been pointed out by others as well (Piliavin 1994; Shinn and Gillespie 1994). Piliavin (1994) for example, suggests that other variables, such as the prevalence of former prison inmates or mental hospital inpatients, might also have been considered. Omitting variables, as well as including variables that covary, can lead to serious errors in estimating the effects of the explanatory variables. Finally, "causal ordering ambiguity," which refers to the possibility that some of the included variables might be causes or consequences of other explanatory variables, is best dealt with by employing structural equations and more sophisticated analytical tools (Piliavin 1994). But overall, Burt herself highlights the shortcomings of this first effort, is careful to point out where the findings veer from logical expectations, and emphasizes that her study should be viewed as an "exploratory endeavor."

A year later, Honig and Filer (1993) modeled the variation in rates of homelessness across 60 metropolitan areas. The authors calculated the per capita rate of homelessness using 1984 Department of Housing and Urban Development (HUD) estimates for each city.[17] Though the HUD estimates were widely criticized as inaccurate, the authors justified their decision by stating that any errors in measurement are likely to be random across the cities and that independent enumeration efforts had confirmed many of the local estimates. Among the explanatory variables were measures of the low-rent housing market (cost, vacancy rate, and

[17]Other dependent variables not reported on here were the rate of crowding (more than one person per room) and doubling up (more than one nuclear family per rental unit).

presence of rent control), employment market, poverty, public benefits, prevalence of mentally ill individuals, race, and births to teen mothers. The results indicated that the level of rent at the tenth percentile of the rental distribution had the greatest influence on the rate of homelessness, in a positive direction (i.e., leading to increased rates of homelessness). The level of Supplemental Security Income (SSI) benefits was also positively related to homelessness, a result both puzzling to and unexplained by the authors. The level of Aid to Families with Dependent Children (AFDC) benefits, however, is negatively associated with rates of homelessness. Finally, growth in private-sector employment between 1980 and 1982 had a strong, negative impact on rates of homelessness. Among those variables that did not exhibit statistically significant impacts were the presence of rent control and vacancy rates, housing-related variables that are often of particular interest in studies of homelessness.

Two earlier studies that tried to address specifically the role of rent control in determining homeless rates were Tucker (1987) and Quigley (1990). Tucker employed a number of variables measuring elements of the local housing and employment market (in addition to the poverty rate, population, and weather) and used both correlation and multiple regression in analyzing the data. The rate of homelessness (per thousand residents) was used as the dependent variable. He concluded that rent control played a significant role in increasing homelessness so that the immediate policy solution necessary was the abolition of rent control regulations across the nation (Tucker 1989). Quigley (1990) revisits some of Tucker's research, using the same dependent and explanatory variables but adding additional controls for rental prices and household income. He finds that although the additional variables increase the explanatory power of Tucker's model, the coefficient on rent control is reduced by half and it is no longer statistically significant. When Quigley removes the rent control variable entirely, overall explanatory power increases again, and the significance of both the rental price and household income variables increases. This simple exercise highlights the implications of variable selection (and omission) and the impact of methodology employed in these types of studies on the outcomes achieved.

Grimes and Chressanthis (1997) analyze the potential impact of rent control on homelessness, but use a two-stage model to control separately for the factors determining the presence of rent control in a city and the factors (including rent control) that affect the rates of homelessness. The study uses the 1990 census counts of the homeless (relative to the total population) but runs the model of homelessness three times using first just the shelter count, second just the street count, and finally the total count. Explanatory variables included in the rent control model include population density, percent of total housing stock that are renter-

occupied, the rent for an apartment at the 10th percentile of the rent distribution, a political measure of how liberal or conservative the city is and a regional dummy. Once the coefficients for these variables are estimated, they were used to calculate predicted values of rent control for each city, given its actual characteristics. These predicted values of rent control (zero if not present and one if present) for the explanatory rent control variable in the model of homelessness. Other explanatory variables included in the homeless model were measures of population size and density; poverty; age and cost of local housing; per capita Medicaid payments; the local climate; crime; region; and population characteristics (the percent living in group quarters, disabled, or of veteran status and the percent of households that are female-headed). The explanatory power of the homeless model was greatest when the shelter counts and total counts were used ($R^2$= .4192 and .3615 respectively) but very low when just street counts were used ($R^2$= .0897). This is not surprising given that the shelter count is considered to be fairly accurate but the street count highly inaccurate (Wright et al. 1998).

The results suggest that rent control does exert a statistically significant and positive influence on homelessness, but it is a small one; where rent control exists it is expected to increase the shelter count of homeless by only .03 percent and the street count by .008 percent. While other variables had a significant affect in the expected direction—lower access to low-income rental units, higher population size, and density increased rates of homelessness, the size of the impact was always a fraction of a percent. The only exception was the variable for the percent of the total population residing in supervised group quarters other than shelters. The statistically significant coefficient for this variable suggested that a change of one percent in this variable would lead to a two-percent increase in both the shelter and the total homeless counts. The author, however, says very little about the rather small size of these effects.

Most recently, Quigley, Raphael, and Smolensky (forthcoming) incorporated measures of both housing tightness and income inequality in an attempt to empirically test the theory of Brendan O'Flaherty that income inequality contributes to the growth of homelessness. The authors employ slightly varying models with two older data sets, the 1990 census counts and the 1989 Urban Institute counts of homeless and shelter beds in metropolitan areas across the U.S., and two different sets of homeless counts for the 58 counties in California. The explanatory variables included rental vacancy rates, median rents, income, and poverty measures, local unemployment rates, the average temperature in January, the number of SSI recipients per 10,000 residents, and (for the two national data sets) the change in the number of mental hospital inpatient population per 100,000 over the 1980s. The ratio of the fair market rent (paid by the

lowest 40 percent of the local population) to per capita income was used as the measure of income inequality. Their results suggest that when controlling for many of the factors that influence the chance of being homeless, measures of both housing tightness, and to a less degree income inequality, are statistically significant. For all but the Urban Institute data set, the rental vacancy rate exerted a significantly strong and negative influence on homelessness. Measures of income inequality were statistically significant and positive in the models employing the Census data and their preferred data set.[18]

Researchers have used microlevel data to examine the factors that might predict individual vulnerability to housing instability or homelessness. Ringheim (1993) examined how factors affected the probability of Houston residents being "vulnerable" to homelessness in 1976 and 1983. A household was considered vulnerable if its income was below 125 percent of the poverty level and if they pay 45 percent or more of that income for rent. A second classification, "severely vulnerable," described households in which individuals had less than $50 each after the rent was paid. In both years, the factors that were significantly and positively related to the probability of being vulnerable were a household's being "female-headed" and "black-headed," though the strength of the impact of female-headship seemed to decline from 1976 to 1983 whereas the reverse was true of black-headship. As one might expect, the head of householder's level of education was negatively associated with the risk of vulnerability in both years. Having children in the household decreased vulnerability in 1976 but increased it in 1983 suggesting that the situation for families in the rental housing market worsened over time. Residing in substandard housing had a statistically significant but modestly positive effect on vulnerability to homelessness in 1976 but no effect in 1983. Other included variables that had no significant impact on the vulnerability to homelessness were Hispanic head of household, central city location, and severely substandard level of housing.

Early (1998) uses microlevel data on both the homeless (using data from the 1987 Urban Institute survey of the homeless) and the housed (using data from the American Housing Survey) in 15 cities. Motivated by a desire to determine the impact of subsidized housing in deterring homelessness, the author models the probability of being homeless as a function of household and local environment characteristics. He finds that income, depression, and shelter quality are the most important de-

[18]This California data set, administrative data from the Homeless Assistance Program (HAP), counts the number of homeless families eligible for AFDC rather than all homeless individuals.

terminants of homelessness, with the first exhibiting a negative relationship and the latter two a positive one. Gender and ethnicity had a statistically significant impact with males and African-Americans having an increased probability of being homeless. The housing market variables, however, did not have a significant impact on the housing outcome. Early then uses his estimates of the coefficients for each explanatory variable to predict what percentage of those currently receiving housing subsidies in the U.S. would likely be homeless in the absence of those subsidies. He finds that less than five percent of that subsidized population would be homeless without such assistance. In an updated version of this study, Early (1999) alters the included explanatory variables and improves the modeling of the housing decision households face. But the findings are similar with "poor, young, depressed, males facing the greatest risk of becoming homeless" (Early 1999, 325).

Echoing the sentiment stated earlier that analyses of the causes of homelessness are essential to the development of homeless policies, Early states that, "Without a good understanding of which households are most at risk of homelessness, and what policies will lead to substantial decreases in the number of homeless, aid will be misguided" (Early 1999, 325). But as interesting and thought provoking as the existing studies are, it is uncertain how much of an influence quantitative studies of causal factors, in the absence of greater consensus, will have on the policy development process. The researchers themselves are drawn in very different directions with regards to policy solutions. Burt, for example, admits that the range of possibilities is broad (because the causal factors are so numerous) but that in the very least cash assistance in keeping with cost of living increases and expanded subsidies for low-income housing are in order (Burt 1992). Early argues that housing subsidies are not the most effective way of increasing housing options for the poor, advocating instead for weakened housing codes to increase the number of low-quality, but low-cost units available (while also supporting increased public benefits) (Early 1999). Housing markets, local labor markets, and differences in the personal attributes of the homeless taken together suggest that to be effective, policies will have to be devised by, and thus vary across, municipalities and counties.

Though the challenges to such analysis are likely to continue, future efforts will hopefully narrow the differences due to methodology, modeling errors, and other weaknesses. Researchers should benefit from the fact that enumeration techniques have improved over time and increased shelters and service make the homeless more visible. As a result, application of these models to more recent data might yield more consistent findings. If the shortage of affordable housing in this boom economy is a major contributor to current rates of homelessness, as many suggest, this

might also increase the likelihood of estimating the true effect of housing and income variables on homelessness in the future. Nevertheless, it should be noted that consistent empirical findings would not necessarily imply similar optimal policies across jurisdictions.

*Relevance of Causal Theories*

Proponents of structural explanations see an emphasis on personal deficiencies, especially when associating them with lifestyle choice, as a form of "blaming the victim" (Wright et al. 1998, xiv; Hoch and Slayton 1989; Snow et al. 1985). Proponents of individual causal explanations see those espousing structural arguments as being "in denial" about the true causes of homelessness (Baum and Burnes 1993, 7). The causal argument to which one subscribes is important because it exerts a strong influence on the types of policies and interventions espoused (Burt 1997a; Wright et al. 1998). For example, we can imagine on one end of a continuum someone who firmly believes that homelessness is simply a lifestyle choice. Such an individual would propose either punitive policies, designed to force the homeless to make the right decisions, or no policy at all, believing that individual lifestyle choices are not an appropriate realm for government intervention. On the other end of the continuum, a proponent of the structural approach would argue that the government must intervene to correct societal inequities or failures in the private market. An individual occupying the middle ground, believing that personal disabilities are the primary cause of homelessness but that the homeless are victims of these disabilities, would support government intervention in the form of funding for treatment and other services.

Proponents of structural theories have been accused of trying to "normalize" homelessness, or close the perceived gap between the homeless and the general population, to garner public sympathy and support for more preventive policies. Proponents of individual factors have been said to "medicalize" or "moralize" the issue to push forward their particular service provision agendas (Koegel et al. 1996, 25). This disagreement between these groups might provide one explanation for the seeming failure of public policy thus far to effectively address the challenges presented by homelessness. The resulting policies are discussed further in Section III.

*Conclusion*

Recent media reports of increasing homelessness often include opinions as to which factors are driving the persistent growth of this social problem. Without exception, those interviewed respond that the primary reason the homeless population is growing is because of soaring rents and housing costs encouraged by a booming economy (U.S. Conference

of Mayors 1999; Bernstein 1999; Brown 2000; Marks 2000). A decade ago, personal deficits would have been thought to be central. Also mentioned, then and now, are a mix of individual and structural factors such as substance abuse, low wages, public policy (particularly welfare reform and the phasing out of rent control) and changes to the shelters/services available. That we will eventually be able to pinpoint how much of homelessness is due to specific factors is unlikely, and perhaps not even necessary. Most researchers now promote a more balanced causal model (Shlay and Rossi 1992; Hamberg and Hopper 1992; Burt 1992), one that incorporates both individual and structural factors as proximal and ultimate causes and allows for these factors to interact differently over space and time. For example, such a "reconciliation" can be achieved by imagining that structural factors and public policies create an "at-risk population" and personal deficits or disabilities determine which at-risk individuals become homeless (Wright et al. 1998, 9; Ringheim 1990). The end result is that ideally none of the factors should be overlooked when evaluating possible impacts on homelessness, and emerging policy solutions should address all of the factors involved in developing a complex and comprehensive response. Each policy option should be pursued until, at the margin, they are all equally cost-effective in each local housing market.

## Section III: Fashioning a Response

That homelessness surged during the early 1980s would not have seemed extraordinary considering the nation was in the midst of a recession. But the increased visibility of the least fortunate, and their persisting presence even after the economy began to rebound, suggested something new about homelessness. Over the course of the 1980s, it became accepted that increases in homelessness were a new social problem, distinct from patterns of homelessness in the past, that is, a problem no longer necessarily tied to economic cycles. A continuous stream of research made the homeless one of the most-studied groups in the population, and the findings of these undertakings came to guide the response. Details of homeless characteristics and behaviors provided the justification for the local provision of services and the treatment of individual disabilities. Later, causal theories emphasized larger societal and economic factors best addressed through federal policies. Increasingly, money was devoted to solutions by all sectors and at all levels of government. But when the magnitude of the problem failed to decrease, or even hold constant, many began to call into question the effectiveness of the nation's response to the problem. As Christopher Jencks wrote, "On a

political level, the spread of homelessness suggests that something has gone fundamentally wrong with America's economic or social institutions" (Jencks 1994, v).

Today, amidst one of the nation's most prosperous times, surveys continue to document an increasing number of Americans experiencing homelessness and a persistently growing demand for emergency services (Urban Institute 2000; U.S. Conference of Mayors 1999). Like the persistence of homelessness throughout the 1980s, homelessness today suggests that economic prosperity is not a cure; that it does not benefit all equally and perhaps even harms the most economically vulnerable (Shlay and Rossi 1992; Logan and Molotch 1987; Freeman and Hall 1987). This would be so, if for example boom periods tend to tighten the housing market faster than increased job opportunities and wages benefit the most economically disadvantaged. Despite the large sums of money spent and services provided, it remains clear that the problem is not decreasing in magnitude but growing. But if, as the numbers suggest, fewer than two percent of Americans are affected by homelessness yearly, why are we unable to make significant progress in solving the homeless problem? In an attempt to answer this question, this section provides an overview of the policy and other responses to homelessness since the 1980s. In doing so, the literature on possible solutions, barriers to solutions, and lessons learned with regards to the effectiveness of alternative solutions are summarized.

## Possible Solutions to Homelessness

Because earlier homeless populations were viewed as fairly homogenous, initial responses to the homeless crisis tended to fall into one category—emergency food and shelter provision. But over time, information gathered via characteristic surveys and evaluations of service implementation made clear that the homeless were a heterogeneous population with a diverse set of shelter and service needs. As a result, a perceptible shift has occurred in the types of policy responses that are selected from the full array of possible solutions. The programs and services offered are often categorized in terms of the subgroup of homeless at which they are targeted.

Two ways of classifying homeless individuals are common. One is by the duration or nature of homelessness—temporary, episodic, and chronic (Interagency Council on the Homeless 1999). The temporary homeless are those who are in their current situation because they are "down-on-their-luck" or facing a short-term crisis. Not facing a number of barriers to work or independent living, they should be able to and of-

ten do transition back to self-sufficiency with a limited amount of assistance and within a short period of time. The episodic homeless may face limited barriers to self-sufficiency—limited education or work experience, inadequate independent living skills, and perhaps substance abuse issues or mild mental health issues—which make it difficult to maintain long-term and stable housing without specialized services. The chronic homeless tend to spend long periods on the streets or in shelters because they face serious obstacles to obtaining self-sufficiency—severe mental disorders, chronic substance or drug addiction, and other chronic health disabilities—which require intensive treatment and continuous access to services. The perceived distinctions between these subgroups of homeless often guide what type of shelter is deemed most appropriate and what types of services are most efficacious.

The second common classification scheme focuses on the programs and services offered in response to homelessness and can be classified by whether they offer an emergency intervention or preventive approach to the problem. Réne Jahiel (1992b) offers a useful framework for understanding policy responses by applying a three-stage public health model of prevention to homelessness. Primary intervention includes services and programs that work to prevent homelessness from occurring (among the never homeless) or reoccurring (among the formerly homeless). Secondary intervention provides the necessary assistance to help individuals and families transition from homelessness to independent living as productive members of society. Finally, tertiary interventions, such as emergency food, shelter, and health care, provide the services that minimize the harm encountered while homeless.

Tertiary or emergency interventions have been the primary response to homelessness in the United States (Redburn and Buss 1986; Buss 1990). One reason is that the services they represent address the most basic and often most urgent needs of the homeless. Today, they are generally short-term solutions meant to assist those in temporary crisis or to provide a first step in a progression of services for those with greater needs. To the extent possible and necessary, individuals are prepared for self-sufficiency and housing with secondary or transitional services to address mental health, substance abuse, and educational or employment needs. While these secondary preventive services targeted to the currently homeless can help prevent further instances of housing instability, they do not address the larger structural causes that can cause individuals or families to experience first-time homelessness. Examples of policies that fit Jahiel's definition of primary prevention include housing subsidies, income supports, and others that aim to increase the affordable housing stock or raise the incomes of the poor so they can afford the existing stock of housing (Wright et al.1998; Lindblom 1997; Shlay and

**Figure 1: Responding to Homelessness, a Useful Framework**

| | Emergency | Preventive |
|---|---|---|
| Temporary | Shelters and food kitchens<br>Healthcare<br>Counseling<br>Employment & housing services | Increase affordable housing<br>Increase Income of the poor<br>Eviction and displacement prevention |
| Episodic/Chronic | Shelters and food kitchens<br>Healthcare<br>Counseling<br>Detox & substance abuse treatment<br>Mental health care<br>Employment & housing services | Increase transitional and supportive housing<br>Increase affordable housing<br>Increase community access to treatment<br>Institutional release programs |

Rossi 1992). They include programs that make mental health care and treatment for substance abuse or addiction more accessible at the community level.

Other homeless prevention services assist those at risk of being evicted from their current residence, those having difficulties in share-housing situations, those being displaced by housing conversion or destruction, and those being released from institutions, including mental health, facilities, foster care, and incarceration (Lindblom 1997). The reform of local ordinances that hinder the development of low-income housing or facilitate the destruction of existing housing would also be considered preventive solutions to homelessness (Wright et al. 1998; Shlay and Rossi 1992; Hartman and Zigas 1991).

Figure 1 incorporates both approaches to categorizing homeless policies and programs. Here the episodic and chronic subgroups are grouped together, because they share a need for more extensive services, while both the secondary (transitional) and primary (preventive) interventions are grouped together as "preventive." The emergency services and programs are fairly uncontroversial because they target individuals who are obviously homeless, satisfy basic human needs and provide public goods in the sense that they remove the homeless from more visible street locations and address public health concerns. Preventive measures have not

always been as widely practiced or accepted for a number of reasons. Though political, ideological, and other reasons are discussed in greater detail below, it is worth mentioning some issues here. Though researchers have learned a great deal about the predictors of individual homelessness, it is not always possible to know who is about to become homeless and is in need of eviction prevention services until that individual or family seeks assistance. Programs that give preference to homeless families or individuals, such as targeted rental vouchers or other affordable housing programs, are often accused of discriminating against the working poor who might be precariously housed, or of creating a perverse incentive to become temporarily homeless. Untargeted programs to increase the stock of affordable housing benefit a larger pool of recipients but often conflict with calls for limited government intervention in private markets. But research has focused on the increased effectiveness and cost savings of providing transitional housing and services over short-term emergency assistance, and preventing or reducing episodes of homelessness by making housing more affordable.

One type of policy response not included here pertains to that portion of the chronic or potentially chronic homeless unwilling to accept (because of mental illness) or uninterested in accepting assistance in overcoming their condition. Because these individuals often will not willingly take advantage of emergency or longer-term assistance when available, many localities are struggling with policies that will force individuals to receive treatment or engage in programs that could result in housing and economic stability. For example, legislators and others are currently pursuing policies that will facilitate involuntary commitment of the severely mentally ill (*San Francisco Chronicle* 1999). And in the well-publicized case of New York City, authorities have tried to implement a combination of policies that restrict sleeping in public and other visible activities of the homeless. If found sleeping in public, individuals would have the option to stay in a local shelter or be incarcerated. Though currently stalled in the courts, the proposed shelter policy would make able-bodied adult residents of shelters engage in work activities or be evicted (and potentially incarcerated). Devising policy and program solutions that will alleviate the dilemma posed by those unwilling to seek or accept help is likely to remain a challenge in the coming years.

Determining how many individuals are in need of the various types of housing and services is a tricky business. Some potentially in need of preventive policies are hidden from view. They include precariously housed, doubled-up families, and those who are not securely employed or lack steady income. The visible homeless, those who utilize shelters and food programs as well as those who sleep in public places or abandoned buildings, are only slightly easier to classify. Determining who is

temporarily, episodically, or chronically homeless often depends on the duration of an individual's current episode and/or the total number of episodes experienced over a lifetime. Martha Burt and others at the Urban Institute use the following definitions: (1) crisis—currently in the first spell of homelessness and that spell has lasted 12 months or less; (2) episodic—currently in the second (or higher) spell of homelessness and the current spell has lasted 12 months or less; and (3) chronic—the current spell has lasted longer than 12 months, regardless of the number of spells. Applying these definitions to the most recent data from the National Survey of Homeless Assistance Providers and Clients,[19] Burt calculated that 20 percent of the national homeless population could be classified as crisis, 24 percent as episodic, and 56 percent as chronic.[20]

Clearly, the mix of programs and services offered in a given locality should accommodate the local homeless population. Trends in characteristics and subgroups are important for planning service and designing future policies. For example, the fact that more families and working poor are at least temporarily utilizing shelters in certain urban areas suggests that preventive policies addressing housing and income should receive greater emphasis if growth in the number of homeless is to decrease.

The next two sections detail the American response to homelessness—what policies have actually emerged and theories of the factors that have influenced the development of such policies.

## Responding to Homelessness in the United States

Prior to the 1980s, homelessness had historically been viewed as the responsibility of the localities, with religious and other nonprofits providing the primary response. Since the late 1980s, the federal role in combatting homelessness has increased steadily. The degree to which certain

[19]As with most point-in-time surveys, the NSHAPC sample most likely overrepresents the chronically homeless. However, this may be offset by the sample underrepresenting the street homeless who do not utilize any organized services, who may also be more likely to be long-term or chronic homeless.

[20]The method preferred by Burt et al. involves using cluster analysis with the same two variables, number of spells and duration of current spell. They find that 27 percent of the sample had an average of 1.6 spells with the current spell averaging 50.2 months; 17 percent had an average of 7.4 spells, with a current spell averaging 11.3 months; and 56 percent had an average of 1.9 spells and a current spell lasting an average of 9.1 months (Burt, Aron, Lee, and Valente Forthcoming).

types of homeless intervention have been pursued in the United States has shifted over time, as the following review will show. Tertiary or emergency programs dominated the responses to homelessness at all levels of governments and by all sectors, particularly in the 1980s. More recently, changes in political administrations, the increased availability of federal resources, and improved understanding of homeless populations and programs have been accompanied by a growing emphasis on transitional or secondary services.

Though always present to some degree in modern American society, homelessness increased dramatically in the early 1980s and was perceived by many as a symptom of the 1981-82 recession (Burt 1997a). Local resources were quickly overwhelmed by the demand for emergency food and shelter, particularly in large, urban areas. The federal government established the Federal Interagency Task Force on Food and Shelter for the Homeless in 1983. The task force, operating under the premise that homelessness was a local problem and that a new federal program was not the appropriate response, mainly provided information on how agencies could obtain surplus blankets, cots, and clothing (Foscarinis 1996). Approximately $140 million dollars in federal funds were made available via the Emergency Food and Shelter Program operated by the Federal Emergency Management Agency. In 1984, an additional $70 million was made available to meet the continuing problem.

While the federal government remained primarily in the background, local actors motivated by the dearth of services for those in need, helped raise the salience of the issue. A great deal of credit for advances in service provision over the 1980s has been given to homeless advocates—former homeless individuals, service providers, lawyers, health professionals, and members of the clergy (Jahiel 1992b; Foscarinis 1996; Marcuse 1988). Together, they succeeded in increasing the visibility of the issue by stimulating court and legislative action and promoting service programs. Privately funded demonstration projects served as models for federal pilot programs.[21] Because intervention was limited to tertiary emergency services, the main outcomes of these efforts were short-term shelters and food programs. The growth in homeless families with children, particularly in New York City where homeless families increasingly resided in expensive welfare hotels, drew tremendous media atten-

[21]One such example was the model of health care for the homeless developed by Philip Brickner and other health professionals at St. Vincent's Hospital in New York. Funded by Robert Wood Johnson Foundation and the Pew Trust, the Health Care for the Homeless Project built on this model in providing health care to the homeless in 19 urban areas. In 1988, the federal Health Care for the Homeless Program began operating in 41 states.

tion and prompted early demands for housing solutions (Shlay and Rossi 1992; Jahiel 1992b).

As the nation recovered from recession, homelessness continued to increase seemingly independent of economic cycles or general rates of poverty. This, and the fact that the characteristics of the homeless changed (younger, more family members, and more minorities), suggested a disturbing new social problem, distinct from the earlier hobo phenomenon, a "new" type of homelessness (Marcuse 1988; Freeman and Hall 1987; Wright and Lam 1987; and Redburn and Buss 1986). Perhaps in acknowledgment of this change, the federal government got involved through sponsored research by the National Institute on Mental Health (characteristics and needs) and HUD (to count the homeless and shelter beds). Major federal legislation was absent until Senator Gore and Representative Leland sponsored the Homeless Person's Survival Act in 1986. The act addressed the long-term needs of the homeless, but failed to pass (Jahiel 1992b). The Homeless Eligibility Clarification Act and the Homeless Housing Act, both passed in 1986, made it easier for homeless individuals to participate in federal means-tested benefits and provided $15 million in federal grant money (two-thirds for an Emergency Shelter Program and one-third for a Transitional Housing Demonstration Program) (Foscarinis 1996).

Signed into law in 1987 by President Ronald Reagan, the Stuart B. McKinney Act authorized the first serious commitment of federal funds to homeless programs and services—approximately $1 billion over the first two years.[22] Though the act primarily emphasized emergency services, funding was available for transitional housing and mobile health care. McKinney funds were administered primarily through the Department of Housing and Urban Development who in turn provided grants directly to local governmental agencies and private organizations (Jahiel 1992b).

In 1989, the McKinney programs were reauthorized and expanded, the Interagency Council on the Homeless was created to provide oversight and coordination assistance (Jahiel 1992b), and federal funding via a variety of programs continued to increase. Recent funding levels for the Homeless Assistance Grant,[23] operated by HUD, increased from $823

[22]Actual appropriations for the first two years were $350 million in 1987 and $362 million in 1988 (Foscarinis, 1996).

[23]Funding for the Homeless Assistance Grant is divided among four programs—Section 8 Moderate Rehabilitation Single Room Occupancy Program, Shelter Plus Care Program, Supportive Housing Program, and Emergency Shelter Program.

million in 1996 to just over a billion dollars in 2000.[24] In addition, HUD funding for homeless and other special population programs is made available through the Housing Opportunities for Persons with AIDS (HOPWA), the Home Investment Program (HOME), and the Community Development Block Grant Program (CDBG). The Department of Health and Human Services (HHS) distributes federal dollars through a number of homeless and homeless-related programs. These include the Health Care for the Homeless Program and a number of smaller programs providing services, education, and emergency shelter for battered women, runaway and homeless teens, the mentally ill, and substance abusers. The combined appropriations for these HHS programs increased from $231 million in 1995 to $285.4 in 1998.[25]

Though emergency services and programs initially received the greatest emphasis, transitional programs began gaining support in the late 1980s. HUD incorporated the concept of transitional housing for the homeless into the federal response by creating the Supportive Housing Demonstration Program within the McKinney legislation.[26] Initially, it consisted of longer-term (up to two years) transitional housing with in-house supportive services for the general homeless population and permanent housing for the disabled or chronically ill homeless. In 1992, the program became permanent and was renamed the Supportive Housing Program. In recent years Supportive Housing has been the most generously funded of the Homeless Assistance Grant programs, receiving approximately 70 percent those total funds—$602 of $917 million in 1995 and $577 of $823 million in1996.

Also in the 1990s, the federal government became increasingly concerned with the effectiveness of its programs and with achieving accountability for the funds that had been invested. HUD ordered a number of evaluations of programs funded since 1987. Though short-term in focus, the evaluations conducted by Abt Associates and Westat, Inc. provided a great deal of information on the impact of the various homeless programs and services on individual participants. Among the findings: 70 percent of those completing transitional housing programs find permanent housing; 85 percent were still in permanent housing after one year of entry; employment and earnings could be increased through job training programs; and considerable cost-savings could be realized from the

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[24]Sources of data include the HUD website at http://www.hud.gov and a HUD report entitled "Opening Doors for More Americans: Leading Communities into the New Century. Fiscal Year 2000 budget Summary, February 1999.

[25] Data available at: http://aspe.hhs.gov/progsys/homeless/bugt1.htm.

[26]For a full description please see: http://www.huduser.org:80/publications/homeless/mckin/shdp.html.

improved physical and mental health of housed individuals.[27] Other findings emphasized that the long-term homeless, particularly the severely mentally ill and chronic substance abusers, needed transitional housing prior to permanent housing, and that supportive housing could bring these highly marginalized individuals back into the community.[28] These findings supported the accelerating shift to transitional housing and services noted above.

In 1993, the Clinton Administration attempted to weave the lessons learned from the early McKinney programs into a comprehensive framework to guide future efforts to combat homelessness. This framework was called the "Continuum of Care." The concept emphasizes a continuous delivery of services from emergency interventions to preventive programs, encourages assessment of local needs, inventorying of available resources, identification of service gaps, and coordination of all local efforts (public and private) to serve the homeless population. Organizations and agencies applying for federal Homeless Assistance Grant support must demonstrate that a local continuum of care is in place and that the services to be funded fall within this continuum. Academic research has suggested that funding and administrative assistance made available through the Homelessness Assistance Grant programs have contributed significantly to local preparedness (Berman and West 1997).

Though the federal response to homelessness increased over time, the main responsibility for addressing the issue remained at the local level, particularly in the hands of nonprofit organizations. While federal monies were most often distributed to states, localities, and local housing authorities, the majority of it was passed through to nonprofit organizations that provided approximately 80 percent of homeless housing and services (HUD 1995). Most recently, NSHAPC data revealed that in February of 1996 nonprofit organizations operated 85 percent of homeless shelters and service programs, government agencies another 14 percent, and for-profits only one percent (Interagency Council on the Homelessness 1999). Like the shift in federal funding, or perhaps explaining that trend, local service providers have increasingly moved to transitional and longer-term programs for the homeless. From 1988 to 1996, the number of shelter beds available to the homeless increased 220 percent, from 275,000 to 608,000. Of this 333,000-bed increase, 224,680 beds were in

[27]For a full account of these findings, please see the publication, "Stewart B. McKinney Homeless Programs: Policy Development &Research Report to Congress, January 1995, available at http://www.huduser.org.

[28]Detailed findings can be obtained from the Abt Associates website (www.abtassoc.com) or the Corporation for Supportive Housing website (www.csh.org).

transitional or permanent housing programs rather than emergency shelters. (Urban Institute, 2000)

## Explaining the Response

A number of researchers have attempted to explain the nation's response to homelessness over the past two decades. The primary focus of these efforts has been to identify the factors that influenced the nature or degree of the response as well as the timing. In particular, researchers and practitioners have sought to explain the perceived failure of the United States to develop more preventive policies—those that address the root or structural causes of homelessness—or significantly expand preventive programs currently in operation. Some see a disconnect between what we now know about homelessness and program efficacy and what we are doing to resolve the problem (Jahiel 1992a). For example, it has been said that the most cited explanation for increased homelessness during the 1980s was the decline in affordable housing (Burt 1997b). If that is true, what explains the fact that a significant increase in affordable housing was not the primary federal response to homelessness? And if continuing growth in homelessness today is attributed to a housing crisis, doesn't it seem reasonable to expect greater experimentation and implementation of preventive interventions?

One factor thought to be influential in shaping the federal response was the political and ideological environment of the 1980s. Many saw the Reagan and Bush administrations as dominated by conservative ideology and economic principles that promoted notions of unfettered capitalism and individual responsibility for economic success (Jahiel 1992c). To encourage work and discourage dependency on government assistance, the social wage had to be kept below the level of the labor wage (Blau 1992). It was fairly common to hear people speak of homelessness as a personal choice. Given the context, that the initial federal response was not larger or more preventive in nature may not be nearly as surprising as that legislation such as the McKinney Act passed at all. One explanation for the passage of McKinney was the well-documented efforts by advocates and the homeless themselves to put the issue of homelessness on the policy agenda (Marcuse 1988; Blau 1992). Their organized events and demonstrations, well-covered by the media, managed to grab the attention of the nation and garner support for the cause. Policy solutions emerged because people were able to define the problem as one amenable to human action and assign responsibility for that action to a particular agent (Stone 1989). Because so many different policies and trends contributed to homelessness in the 1980s, it was hard

to say who was responsible for solving it. Advocates clearly seem to have been effective in making the federal government seem the target, though some people questioned their portrayal of the homeless, in terms of demographics and other characteristics (Jahiel 1992c). Certain segments of the homeless, the disabled or families, are often emphasized (or de-emphasized) in media reports or advocacy efforts to garner maximum sympathy (Burt 1992; Wright 1988). The public, inspired by traditional notions of charity, responded favorably to the advocacy movement and supported calls for government action (Marcuse 1988).

But even though advocates may have succeeded in putting homelessness on the policy agenda, the response was still constrained by political and ideological factors at play. As a result, a consensus arose to provide emergency services and shelter rather than address the more structural causes of homelessness (Jahiel 1992b). Others have suggested that providing modest ameliorative responses was one way of at least doing something to address the issue (Marcuse 1988; Wright et al. 1998). By relieving public pressure for action, the federal government and localities could avoid adopting more costly solutions or redistributive policies that speak to the structural theories of homelessness. Tertiary responses to homelessness avoid the opposition of those advantaged by the status quo (Jahiel 1992b).

In a more positive light, the policies and programs that emerged during the 1980s could be viewed as a logical response to what was viewed as a temporary crisis brought on by an economic recession. If increased homelessness was caused by the recession, then the justified response would be to provide emergency shelter and short-term assistance until the economy rebounded. Others viewed the early responses as "the first step toward a more comprehensive federal response" (Foscarinis 1996). There is disagreement as to whether developments in the 1990s have provided adequate or satisfactory follow. The past decade has witnessed the expansion of transitional and longer-term programs with support services, as discussed above, and a great number of improvements in delivery and integration of needed homeless services. They have been accompanied by a growing trend in the use of punitive methods, such as criminalization, for dealing with the homeless. The coexistence of two such contrasting responses to homelessness suggests the operation of different sets of factors.

Some have commented that after the initial entry of the federal government in 1987 and a few years of program expansion, homelessness faded as a political issue. Some attributed this to a sense that homelessness simply became routine or expected in daily life and ceased to elicit sympathy or public demands for action (Hopper 1998). Some saw new policy issues overshadowing homelessness (Wright et al. 1998). Others

felt that at least in some areas, the increased availability of shelters and other programs made the homeless less visible, or that efforts to move the homeless to the periphery of urban areas gave the public a sense that the problem had been solved (*The Economist* 2000). A changing political environment was viewed as contributing to decreasing interest in homelessness and other issues of poverty. Whereas in the past, Democrats were seen as championing the causes of the least fortunate Americans, in the 1990s they appeared more moderate and concerned with appealing to the interests of middle-class voters, as Clinton's support for welfare reform seemed to indicate (Ratnesar 1999; Jahiel 1992c). It is also possible that the nature of advocacy shifted somewhat from that of the 1980s. If early images of the homeless promoted a sense that they were "just like you and me," some perceived a growing disassociation between the homeless and other vulnerable groups in the early 1990s. Smaller interest groups formed—the elderly, the disabled—and this could have resulted in a politically weakened coalition trying to advance the agenda of those most likely to be viewed as the "undeserving" homeless or poor—the able-bodied, the substance abusers, etc. (Jahiel 1992c).

The changing perception of the homeless may have contributed to the emergence of more punitive policies for dealing with homelessness during the most recent recession and continuing today. Such policies, often referred to as "mean policies," criminalize or severely restrict the activities deemed necessary by those living in public spaces, such as sleeping, panhandling, and even sitting. According to the National Law Center on Homelessness and Poverty (NLCHP 1999) 85 percent of cities surveyed in 1998 had imposed laws to prohibit or restrict begging, and 73 percent had prohibited or restricted camping or sleeping in public. And the trend certainly seems to be upward—among those same cities in 1994, only 26 percent had ordinances pertaining to camping or sleeping in public (NLCHP 1999). These policies have been linked to increased urban revitalization and improving the "quality of life" efforts as well as compassion fatigue among the public and a sense that shelter and service provision has failed (Maggs 1999; Nieves 1999). But public opinion polls have repeatedly rejected the idea of compassion fatigue (Link et al. 1996; Toro and McDonell 1992; Gallup Organization 2000), suggesting perhaps that local promotion of punitive policies are driven by a small but economically powerful or politically vocal minority. Perhaps another outcome tied to an increase in mean policies is the increasing trend in NIMBY-ism, the "Not In My Backyard" syndrome that is creating considerable obstacles to the siting of homeless programs, often leading to delayed or canceled projects and increased development costs (NLCHP 1997).

In contrast to these responses, states and localities have continued to expand transitional and supportive housing programs, despite the barriers they face. In addition to increasing federal support, recent state budgets include significant new funding for homeless programs, especially those serving the mentally ill, and affordable housing. California led the way with $25 million for supportive housing, $35 million for emergency and transitional housing, $55 million for community mental health services for the homeless, and $188 million for affordable housing, among a variety of other housing-related provisions in the 2000-01 budget.[29] Minnesota, Connecticut, New Jersey, and New York committed significant state funding for affordable housing, supportive housing, and other programs. What are the possible factors contributing to this growth in financial support? Undoubtedly the booming economy and government surpluses are one factor. And perhaps as mentioned previously, continuing research on the cost-effectiveness and successful outcomes of specialized housing programs are informing the policy development process. Perhaps also at work is the fact that the current housing crisis seems to be reaching higher into the income distribution, making it difficult not just for the poorest Americans to find stable housing, but for even middle-class individuals and families. This has effectively broadened the support base for affordable housing efforts and could explain the current willingness to commit government funds to new construction of housing units.

## Current Practices in Responding to Homelessness

Despite the dogged persistence of homelessness, a number of new and existing programs across the nation provide evidence that homelessness is not an intractable problem. Though the environment faced by service providers, local leaders, and policymakers is as challenging as in the past, innovative approaches to old problems demonstrate successful strategies to provide services and housing for the homeless. There are innumerable examples of "best practice" cases in dealing with nearly every aspect of homelessness.[30] The primary focus here is on highlighting some practices dealing with the hardest-to-serve population of the homeless (severely mentally ill and chronic substance users), methods

[29]Information obtained from a Corporation for Supportive Housing update—"Supportive Housing and the State Legislatures: California puts major resources into supportive housing for first time."

[30]For examples, please see the HUD website: http://www.hud.gov:80/best practices or the Homebase website: http://thecity.sfsu. edu/~homebase/hud/htm.

for overcoming local opposition to homeless facilities, and innovative and equitable programs for housing and other service provision.

*Helping the Hard-to-Serve*

Since the McKinney homeless programs were first funded in 1987, there has been considerable growth in programs and services designed specifically for those homeless challenged by mental illness, physical disability, substance abuse or HIV/AIDS (Fuchs and McAllister 1996). But specialized programs can only benefit those who choose to participate. Those who do not seek treatment or refuse it because they are unable or unwilling to perceive their need for assistance are among the most visible of homeless. Their prolonged exposure to life on the streets not only subjects them to heightened risk of harm, but often leads to a cycling from homelessness to incarceration or hospitalization and once again to homelessness, a cycle that is both detrimental to the individual and costly to society. A number of innovative programs work to reduce the harm experienced by such individuals while homeless, increase the likelihood that they will voluntarily seek assistance, and break the cycling in and out of homelessness.

In California, a three-county demonstration project tackles the problems of inadequate community mental health services and the resulting population of hard-to-serve and mentally ill homeless. Assembly Bill 34, authored by Assemblyman Darrell Steinberg (D-Sacramento) provided $10 million in 1999 for a pilot program to conduct outreach to and provide shelter and treatment referrals for the mentally ill homeless. The pilot program in Los Angeles, Sacramento, and Stanislaus counties targets preventive services at individuals soon to be released from hospital emergency rooms, county jails, and other facilities who are at risk of becoming homeless because of their mental health disorders. It works with currently homeless and mentally ill individuals sleeping outdoors, slowly trying to establish trust so they might eventually accept referrals to available treatment services and shelter. As of June 2000, the program assisted 1,200 individuals (900 in Los Angeles alone) and early data suggests that the number of days in hospital declined 64 percent, days in jail declined 73 percent, and the number of days spent homeless fell 58 percent (Rivera 2000a). Encouraged by the results, Governor Gray Davis increased the funding to $55 million in the 2000-01 California budget.

Efforts to prevent vulnerable individuals from becoming homeless and joining the ranks of the hard-to-serve have been documented elsewhere. Massachusetts, working through both the Department of Correction and the Department of Public Health, has implemented policies to reduce the number of individuals leaving correctional facilities who become homeless (U.S. General Accounting Office 1999). Resources are

now devoted to planning housing and services for the inmates who will soon be discharged, and recovery beds are reserved for those with substance abuse issues. The program tries to secure appropriate housing for inpatients in psychiatric hospitals prior to their being released.

Under a pilot program in King County, Washington, the mentally ill charged with misdemeanors receive court-ordered treatment (with temporary housing, support services, and individual treatment) rather than prosecution and sentencing. Local officials estimate that one-third of those who will benefit from this policy change are homeless and that many more are at risk of becoming homeless if incarcerated (U.S. General Accounting Office 1999). San Diego County created a special court to deal with the minor offenses homeless individuals are often charged with including panhandling, public urination, or sleeping in doorways (Perry, 2000). Rather than having to serve jail time or being issued fines they are not likely to pay, the homeless are given credit for enrolling in a shelter and other service programs, or doing volunteer work.

Other innovative outreach programs have tried to deal with the effects of local criminalization policies. Since police are responsible for enforcing such policies, service providers and advocates have teamed up with local police departments to deal with the most visible homeless. In Broward County, Florida, the Broward Coalition for the Homeless established a police sensitivity training program to educate officers about the homeless population and encourage referrals to available shelters rather than issuing citations, making arrests, and incarcerating the homeless (Brown 1999). In Sacramento, California, Project HOPE pairs police with social workers in an attempt to encourage mentally ill homeless people to go to available facilities for treatment (Hoge, 2000). In Portland, Oregon, police officers work together with outreach workers from JOIN: A Center for Involvement to identify encampments targeted for removal and to refer homeless campers to local shelters and other services before removal occurs (Brown 1999).

In addition to outreach, referral and homeless prevention efforts, some programs operating under the philosophy of "harm reduction" offer shelter and support services to individuals not likely to seek treatment or screened out of other programs (because of current substance use or other inability to abide by rules). The principle of harm reduction has been described as "meeting clients where they are to help them reduce harm associated with their lifestyle choices and circumstances." It particularly applies to those who are currently using drugs and alcohol (Lenoir 2000, 31). Since development of trust in service providers and reaching a crisis point generally precede seeking assistance for substance abuse, providing harm reduction services and safe havens can decrease the likelihood of illness, death, violence, and disease transmission until

the crisis occurs. One example of a supportive housing program operating under this principle is the Health, Housing and Integrated Services Network (HHISN), an initiative of the California Corporation for Supportive Housing in northern California. HHISN agencies provide safe and service-enriched housing for the hard-to-serve homeless population. Though it is presumed that individuals will continue their drug use, such behavior is not condoned. Policies ensure that substance-using behavior will not disturb the safety and well-being of others, and services aid in reducing or halting such use. Vocational and employment services aim to achieve long-term outcomes in line with the individual's goals and abilities. Early evaluation of some HHISN participants reveal significant reductions in hospital inpatient days (down 57 percent), emergency room use (down 58 percent), and reduced residential mental health care (reduced to zero days after a year of residency in HHISN housing) (Lenoir, 2000).

*Overcoming the Challenges of NIMBY*

Though the need for housing and services may be documented, and the resources for appropriate facilities secured, homeless programs often do not materialize as a result of opposition from local governments, residents, and business owners. The organized resistance to the siting of shelters, treatment centers, and other service-providing is an example of NIMBY or Not In My Back Yard syndrome (Takahashi 1997), and is often supported by well-funded and politically influential members of the community. NIMBY efforts most often work through the application of zoning laws and building codes in order to delay or prevent an organization from attaining the necessary zoning approval or building permits (NLCHP 1997). The National Law Center for Homelessness and Poverty (NLCHP) (1997) surveyed 92 transitional housing providers located in 71 cities or towns across the nation and found that NIMBY had significant negative impacts on the efforts to establish new facilities by about 40 percent of the programs. Such resistance added additional time and cost to many of these projects.

In the same NLCHP (1997) report, the authors present a number of strategies to avoid, alleviate, or overcome NIMBY opposition. In the planning stages, organizations should try to pick sites least likely to evoke resistance from community members (discussed below) and determine the best ways to educate community members as to the need for and purpose of the proposed facility. To the extent possible, an organization should find ways to involve community members in the siting and development process. Concerns can be addressed by specifying that the design of the building will be compatible with the surrounding environment, that the operation and maintenance of the facility will adhere to

strict rules, and that there will be an established process for the filing and addressing of grievances over time. Some organizations have achieved these objectives by writing a "Good Neighbor Policy" and by establishing a community advisory board (NLCHP 1997, 46, 48). States and local authorities can limit the problems caused by NIMBY by pursuing proactive measures such as revising the current zoning laws or passing legislation that limits the use of zoning laws to prevent the citing of needed services and housing. In some areas, such as the District of Columbia, advocates have used the threat of litigation to successfully achieve the revision of local zoning laws that violated the Federal Housing Act.

HUD made funds available through the Innovative Homeless Demonstration Grant Program to test the effectiveness of such strategies. Some of this funding, $250,000, was used to establish the Community Acceptance Strategies Consortium (CASC) in northern California that works with local and regional service providers to overcome the barriers created by NIMBY (NLCHP 1997). CASC furnishes service providers with technical planning assistance and engages in intervention measures involving public relations, partnering strategies, and legal tactics to obtain siting approval and neighborhood acceptance. Utilizing a two-prong approach—educating the public about the future facility and "immunizing members of the Planning Board from the arguments and influence of the opposition—CASC was able to gain approval for several homeless programs including the Hamilton Family Shelter (Regional Innovative Homeless Initiative 1998). In conjunction with efforts to reform zoning, planning and other policies, community acceptance strategies can reduce the cost of needed service programs.

NIMBY opposition is generally less common when planned services will be sited in low-income or inner cities where a diversity of development already exist, or in primarily business/commercial districts. Fifteen percent of surveyed housing programs sited in commercial neighborhoods experienced local opposition compared with 43 percent in primarily residential neighborhoods of 52 percent in mixed-use areas (NLCHP 1997). NIMBY opposition appears to be more vehement in middle- or upper-class communities than in poorer neighborhoods (Dear 1992; Beggs 1993). In light of this, one ideal solution has been to site planned homeless programs on former military bases or other vacant federal land. Military base property tends to be somewhat isolated or separated from other established communities to begin with so proposals to develop homeless programs or low-income housing are less likely to attract strong opposition. When such resistance does occur, the fact that the land is federally owned and the proposed development achieves objectives of federal law (the McKinney Act or the Fair Housing Act) can often be used to overcome local zoning restrictions. This was certainly the case

with Amandla Crossing, a transitional housing program for homeless families in Edison, New Jersey. The program, which would provide housing for about 27 single-parent families, was initially opposed by local authorities and surrounding neighbors. But after establishing its right to proceed in accordance with the McKinney Act, the program received its zoning approval. In addition, certain elements of the facilities design also worked to allay neighbors' concerns (NLCHP 1997). Among these were the fact that the program's full-time staff members would live on site with their own families (ensuring that they had an interest in maintaining orderly operation of the facility), and the architecture and landscaping of the property was designed to blend in with the surrounding neighborhood.

Another program to benefit from the availability of federal land is a new 60-bed, long-term housing program for the homeless currently being developed on a former military base in northern California with the overwhelming support of the local residents (*LA Times* 2000). Local foundations, corporations, and residents are contributing $900,000 toward the start-up costs and pledging to cover one-third of annual operating costs. One explanation for such generosity is that Marin County residents boast the highest per capita income in California. But beyond that, it is likely that elements of both the program design and overall development plans for the military base have contributed to the community's willingness to support the facility. Those residing in the housing program must abide by strict rules including the maintenance of sobriety, a 6 P.M. curfew and mandatory transitioning into work. Another factor might be the facility's location on a former military base and plans for the entire area to be developed with a variety of housing types, including affordable housing.

In Prince William County, Virginia, SERVE Inc—Securing Emergency Resources through Volunteer Efforts—has received overwhelming support from the local community in its effort to develop a larger shelter and resource center and expand services to accommodate more individuals. The program had reported that only one month into its fundraising campaign it had successfully raised more than $800,000 as well as numerous in-kind donations. The services provided include shelter and other services for the homeless, a food bank, educational programs, and job preparation assistance that can be accessed by other needy individuals in the community. The "one-stop" nature of the program conveys to local businesses and residents that the facility provides valuable service to many of the community members (Joyce 2000). That it will be located adjacent to a large commercial development rather than in the midst of a residential area might have aided its ability to garner community support.

Local residents appear to favor plans that limit the number of beds available and aim to develop housing for the homeless in communities with a mix of affordable and middle-income housing.

In Columbus, the Coalition on Homelessness and Housing in Ohio conducted a survey to determine what types of facility design and siting decisions residents would favor (*Business Wire* 1999). The results indicated that residents favored siting homeless housing units in their own neighborhood if the facilities were small, scattered-site buildings providing permanent housing with full support services. Nearly 90 percent felt that supportive housing for the homeless that is well-maintained and well-designed can blend in with a neighborhood.

Facilities that offer housing or services for the homeless in addition to other low-income individuals, particularly the working poor, appear more likely to gain the support of local residents and businesses. Examples are discussed below.

*Innovative Housing and Service Solutions*

Just as there has been a growing trend in utilizing federal homeless funding for special subgroups of the homeless, we have witnessed a shift in the allocation of funds from emergency shelter to transitional and permanent housing (Fuchs and McAllister 1996). At the same time, increasing need for permanent housing and support services is apparent among the current and recently homeless as well as the working poor and other low-income households. As a result, a number of projects propose solutions that benefit a larger population of those in need. Housing and services for mixed-income and diverse needy populations have the advantage that their expanded eligibility decreases the stigma attached to such programs and garners greater support from local residents and businesses.

One innovative way to create affordable housing in urban areas that is more likely acceptable to local residents is to rehabilitate historic buildings for low-income and mixed housing. Urban areas often have a number of vacant historic buildings and once rehabilitated, units in such buildings are often attractive to individuals with a variety of income levels so mixed-income housing is feasible (Ceraso 1999). Though rehabilitation can be expensive, preservation projects can take advantage of the Historic Rehabilitation Tax Credit (HRTC) and in some cases, the Low-Income Housing Tax Credit as well. Though the units they provide satisfy only a small share of the need, the trend in rehabilitating historic buildings for low- and moderate-income housing has been increasing. In 1997, 42 percent of the 15,025 units rehabilitated were for low- and moderate-income housing, up from only 19 percent in 1993, according to the National Park Service (Ceraso 1999). In 1998, 6,616 units of such

housing were created through the use of the HRTC. Successful projects include the rehabilitation of the Mary Andrews Clark Memorial Home in Los Angeles, which provides 153 units of single-room occupancy (Ceraso 1999) and the Prince George in New York City, which now houses 416 efficiency apartments for low-income workers, formerly homeless, the mentally ill, and people with AIDS (Hoffman 2000). In downtown Los Angeles, the 100-year-old Southern Hotel is being renovated as a single-room occupancy development designed specifically for homeless veterans (Rivera 2000b). This housing program incorporated the feedback of an informal advisory group of veterans and will provide each of the 55 residents with housing vouchers that will limit their share of rent to about a third of the stated rental price ($455 a month).

Another unique approach to the creation of affordable housing can be seen in White Plains, New York, where Sheltering the Homeless is Our Responsibility (SHORE) is developing housing designed to combine home ownership for low-income individuals and families, with affordable rental housing for former homeless families. (Vizard 2000). Each low-income owner will purchase a unit that includes a two-bedroom townhouse with an attached two-bedroom rental apartment that must be rented to a homeless family. Though rental units were in greater demand, SHORE adopted its approach in order to satisfy concerns of city officials and others who felt that home ownership would improve the long-run maintenance of the units.

New services can be made available to a broader base of targeted participants. One recent example is the new educational program offered by the Weingart Center Association in Los Angeles' Skid Row area. The new program will help homeless individuals as well as local low-wage workers (many of them immigrants with limited English skills) develop basic educational skills and prepare for high school equivalency or citizenship exams (Rivera 2000c). Cosponsored by the Los Angeles Unified School District, the program will provide both day and evening classes in math, reading, and English, in addition to computer courses taught in a state-of-the-art computer lab. The program will not only aid those hoping to transition out of homelessness, but will help low-income individuals improve their employment opportunities and economic stability, decreasing their risk of becoming homeless in the future.

*Conclusion*

The above examples of best practices in dealing with homelessness, as well as numerous other cases not covered here, provide valuable lessons on how to deal with the most challenging aspects of the problem. What remains is the task of evaluating the efficacy of many pilot programs and continued documentation of the most successful of these prac-

tices so they can be carried out in other communities and states. As localities assess how well they are meeting the current needs of their homeless populations and where the gaps exist, best practice models may provide the necessary guidance for the redistribution of available resources and the allocation of new resources.

## Section IV: Conclusion

Since homelessness rose to the national agenda in the mid 1980s, a great deal has been learned about the characteristics and experiences of the homeless, the likely factors contributing to rates of homelessness, and what types of policy and program responses tend to be most effective. But the persistence of homelessness in the current economic boom suggests that we still have a considerable amount of work ahead of us.

Efforts to enumerate and survey the homeless have shed light on the magnitude of the homeless problem and what needs must be addressed, but several questions remain. For example, how does the current homeless population break down in terms of how much assistance and support they will need in order to successfully transfer out of homelessness and remain housed? Do these subgroups correspond to the oft-used classifications of temporary, episodic, and chronic? These issues must be clarified at the city or county level if the localities responsible for providing a continuum of care are to successfully accomplish that goal. Furthermore, understanding the trends in this classification over time will not only help localities identify how to distribute limited resources among the needed programs but possibly which causal factors are operating in their region. Attempts to explain why the homeless are more likely to have high school diplomas or be currently employed than in the past speak to the structural factors best addressed by state or federal policies.

Researchers will have an important role in continuing to examine the causal theories of homelessness and understanding how the numerous personal attributes and structural factors interact on both the national and local levels to increase vulnerability to homelessness. One possible avenue for exploration is whether the improved employment prospects and wages during economic boom periods are more than offset by a tighter housing market. Sound and consistent research on the causal theories might facilitate the decision of federal and state governments to propose policies addressing structural factors. Continued efforts are needed to evaluate the efficacy of multiple service provision options, both for the hard-to-serve population as well as those with few barriers to transitioning out of homelessness. More detailed information on long-term outcomes and cost-benefit analysis should enable local authorities and ser-

vice providers to determine which program options offer the greatest probability of success given the characteristics and needs of their local homeless population.

The future response to homelessness will benefit from more thorough and critical examination of the past policy response and the impact it has had on the rates of homelessness as well as treatment of the homeless themselves. For example, while the shift from emergency shelter to transitional or supportive housing programs for the homeless seems to have had positive outcomes, how effective have policies that criminalize activities such as panhandling or sleeping in public been at reducing the numbers of homeless? What have been the implications for the civil rights of the homeless and what of the fiscal impact on other institutions such as the criminal justice and public health systems? How should the concerns of the affected residents and businesses be addressed when setting the policy response to homelessness?

Not only are there outstanding issues in need of further exploration, but the environment in which we find ourselves conveys a sense of timeliness to these issues. Though the number of homeless is at its highest since the Great Depression, the economic boom has provided a wealth of employment opportunities and budgetary resources to invest in social services. Recognizing that low-wage jobs do not necessarily provide earnings sufficient to afford available housing, the federal government and some state governments are significantly expanding housing programs for the first time in many years. For those unable to support themselves through employment, the continued expansion in supportive housing offers an increased chance for permanent housing in the future. But will these housing policies prove sufficient to significantly reducing the number of new or repeat cases of homelessness? And how will the recent changes in public assistance programs embodied in welfare reform affect the future housing vulnerability of families with children and disabled individuals?

If the persistence of homelessness despite prosperous times offends the sensibilities of most Americans, then perhaps our best response is directing our energies and resources to innovative and proactive policies that address the symptoms and combat the causes of homelessness.

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