PUBLIC SECTOR STRATEGIC ADAPTATION: TRANSITIONING SHELTERS TO END HOMELESSNESS

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ABSTRACT

In 2000, the National Alliance to End Homelessness put out a call for the country to end homelessness in ten years. In 2002, under President Bush the program to end homelessness began. At that time the homeless were living in shelters and on the streets. The shift in federal policy was implemented by the Department of Housing and Urban Development (HUD). HUD's "best practice" was to address a minimal stay in the shelter and a swift transition to self-sufficient living in permanent housing. In 2009 the Homeless Emergency Assistance Act and Rapid Transition to Housing (HEARTH) Act was signed into law including the change in funding to ensure the best practice strategy. During this decade the impact of the economic decline had new entrants to homelessness. As funding declines for the homeless it changes the nature of strategic differentiation and opens a new competitive arena – being a low cost provider as noted by Porter.

OVERVIEW

In 2011, more than 1.1 million homeless people were assisted through the Department of Housing and Urban Development (HUD) grant programs. Prior to 2012, Homeless Assistance Grants were available through either competitive or formula based programs. The competitive based programs included Supportive Housing Program (SHP), Shelter Plus Care (S+C) and Section 8 Single Room Occupancy (SRO). The recipients of these awards varied from non-profit organizations to public entities to state and local governments. The formula-based program, known as Emergency Shelter Grants, awarded eligible cities' and towns' monies based upon a specific formula. All funding was made possible through the McKinney-Vento Homeless Assistance Act (MVHAA) of 1987.

In 2009, the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act were signed into law with substantial changes to MVHAA. This law signaled a new shift in homelessness policy and funding away from a continuum of shelter and on-site supportive services to a crisis response system of homelessness prevention and rapid re-housing. HEARTH also created financial incentives for communities to reduce the length of stay in shelter (by 10 percent per year or to less than 20 days on average) and implement rapid re-housing strategies for families. During the past forty years shelters were the primary source of residence for many homeless individuals or families. The original social services paradigm, which continues to be championed by some reformers today, is a holistic approach to evaluate and improve the physical, medical, social, and vocational aspects of a homeless person's life, arguing that if the root causes of homelessness are ameliorated, the individual will transition back into regular society (Schneider, 2009).

FEDERAL POLICY, HOMELESSNESS AND PORTER'S STRATEGY MODEL

In this context, homeless providers differentiated themselves by the comprehensiveness and quality of their service offerings. However, this remediation approach has fallen out of favor. The Ward Family Foundation (2002) noted that the only objective measure of long term effectiveness of homeless programs is the success rate of its graduates in the years subsequent to their departure from the program. Only a limited number of the homeless programs studied maintained contact with graduates of their programs for a period of at least six months to one year, primarily due to a lack of available resources that could be committed to this effort. Consequently accountability is problematic, and opened government homeless shelter programs to a firestorm of criticism. To understand the shift in homeless policy and using Porter's Generic Strategy Model as a way of categorizing low cost and differentiation for profit and nonprofit citation, this model was adapted for one segment of the social services – homelessness. These relationships can be modeled in Figure 1:

Centralized

For-profit / Non-profit Contractors (specific basic services)	Department of Social Services DSS Programs (i.e. Medicare, Medicaid)
Non-profit/private/government providers focused on service niche due to funding cuts (limited scope of basic services)	Non-profit, private, government providers focused on a sub-population niche (i.e. families, singles)

Low cost — **Differentiation**

Decentralized Local

FIGURE 1: HOMELESS PROVIDER STRATEGIC MODEL

In applying the model of Porter's we see the dynamic change in providing housing for the homeless. For the past forty years the homeless needs were met with the holistic approach that received funding from the government agencies and donors to nonprofit agencies. As the homeless population grew and became more obvious it is apparent that the strategy required is changing. The current strategy addresses the need for permanent housing. This change in strategy will create a differentiation of inputs and substitute providers who will enter this new business that will be funded by HUD. The cost advantages will move the homeless more quickly into permanent housing. The competition will motivate nonprofit agencies to become more enterprising. Business looks at increasing its product or service while success in this business will reduce the number of homeless and improve quality of life in the community.

This strategic evolution in providing social services can be understood using two continua. The traditional, long-standing continuum profiles the centralization of the homeless services, ranging from state efforts run by the Department of Social Services (DSS) to local efforts, including private non-profits (Daly, 2013; Jensen & Lolle, 2013). An emerging strategic continuum contrasts the nature of these service strategies. One end of the continuum is anchored by the traditional holistic approach differentiated by the quality and comprehensiveness of the service offerings. The other end is anchored in a low cost approach which offers a more limited slate of services meeting HUD effectiveness criteria. (Daly, 2013; Page, Beatty & Pavlik, 2008). This limited slate of targeted services has attracted the interest of increasing numbers of contractors: "groups of human services for-profits but also several large, well-financed and diversified corporations" (Frumkin & Clark, 2000, p. 145; see also Smith, & Lipsky, 2009).

Aspects of a more holistic approach, unless they could demonstrate clear contributions using the new prevention criteria of effectiveness, are increasingly starved of government funding (Daly, 2013. This changes the nature of strategic differentiation, and opens a new competitive arena-being a low cost provider. This is an opportunity for new entrants to provide the change in needs as HUD has defined creating competitive suppliers as noted in Porter's Five Forces.

IMPLEMENTING STRATEGY FOR CHANGE

The HEARTH Act introduced a cap on the amount of funding that communities can use for traditional shelter and street outreach services in favor of prevention assistance. Such policies pressure homeless service providers to move away from transitional housing programming for families—a program option that provides important services such as vocational training, employment counseling, and parenting classes that address the underlying causes of homelessness—and instead focus on emergency shelter and rapid re-housing.

Contractors

Contractors provide these services faster and cheaper than their government agency counterparts. In order to maintain lower costs, however, these larger for-profit corporate contractors provide a limited set of high margin services to as many homeless people at the state and local levels as possible to maximize profit (Daly, 2013; Smith, & Lipsky, 2009). This skimming strategy focuses on clients relatively easy to service, and has been accused of neglecting individuals requiring more comprehensive and lower margin services (Daly, 2013). Therefore, they often screen for and service those homeless people who have acute, not chronic problems (Frumkin & Clark, 2000).

Department of Social Services (DSS) Programs

These federal and state programs provide services for all homeless people including both chronic and acute. As discussed previously, the DSS programs differentiate themselves from their for-profit competition by offering comprehensive services to any homeless person such as food and nutrition services, basic medical care, independent living skills, employment counseling and job training (Daly, 2013; National Alliance to End Homelessness, 2009).

Focused Service Providers

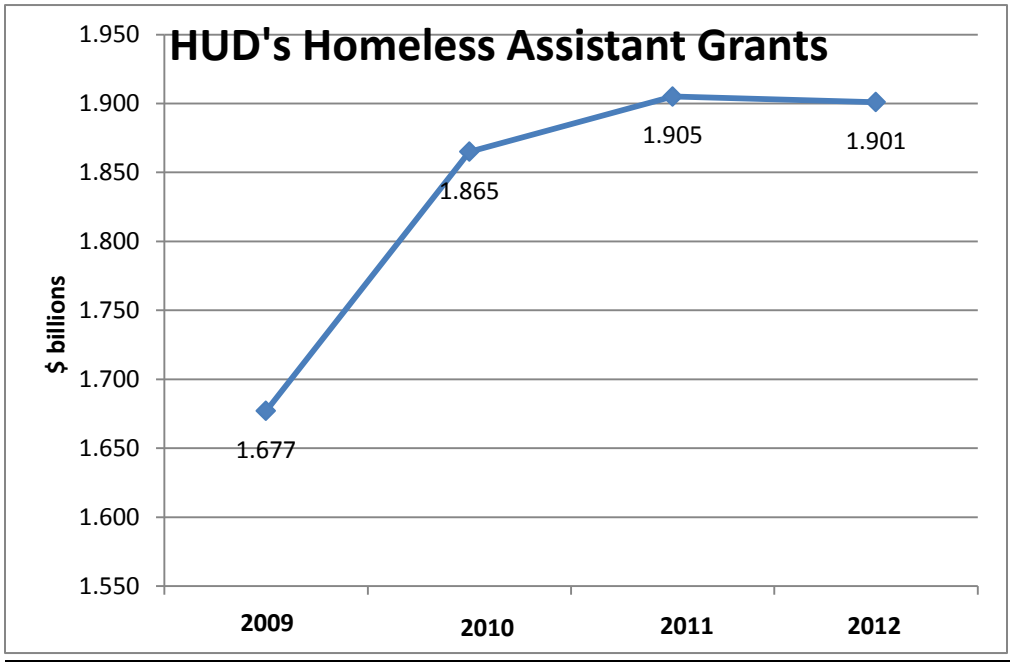
This group (i.e. local programs and charities) provides services for a service niche. They offer the best value proposition by combining effectiveness and low cost (doing more with less) through a restricted scope of programs to service the homeless (Schneider, 2009). These restrictions on services are typically involuntary constraints imposed by declines in funding (Daly, 2013). For example, they may offer non-basic services such as comprehensive evaluation and counseling for new members. This for-profit group can also provide resources sooner with better paid and qualified workers.

Targeted Service Providers

These programs cannot afford to provide services for all homeless people, so they target a specific homeless sub-population as focus differentiators. They customize their comprehensive services such as food and nutrition services, basic medical care, independent living skills, employment counseling and job training on the basis of a specific root cause, such as substance abuse, domestic violence, women and children, disabilities, etc. (Daly, 2013; Jensen & Lolle, 2013).

One amendment consolidated funding for the Supportive Housing Program (SHP), Shelter Plus Care (S+C) and Section 8 Single Room Occupancy (SRO) programs. The funding for a fourth program, Emergency Shelter Grants, was renamed Emergency Solutions Grants (ESG), whose funds were included in the Homeless Assistance Grants program (Table 1).

TABLE 1: HUD'S HOMELESS ASSISTANCE GRANTS (INCLUDES FUNDING OF LEGACY PROGRAMS: ESG, SHP, S+C, SECTION 8 SRO)



DIMENSIONS OF HOMELESSNESS

Definition of Homelessness

Federal law (for purposes of funding for state homelessness assistance programs) defines a homeless person as one who "lacks a fixed, regular, and adequate night-time residence and… has a primary night time residency that is (a) a supervised publicly or privately operated shelter designed to provide temporary living accommodations (b) an institution that provides a temporary residence for individuals intended to be institutionalized, or (c) a public or private place not designed for, or ordinarily used as a regular sleeping accommodation for human beings" (42 U.S.C. 11302 (a). This definition is shared by the National Coalition for the Homeless and the Stewart B. McKinney Act, 42 U. S. C. 11301, et seq. (1994).

Who and How Many People are Homeless

Given the nature of the population being studied, estimates vary, and most of the statistics are limited to the number of homeless people in a specified region. In a recent approximation *USA Today* estimated 1.6 million people (unduplicated persons) used transitional housing or emergency shelters. Of these people, approximately one-third were members of households with children, a nine percent increase since 2007 (Bello, 2010). Another approximation is from the study done by the National Law Center on Homelessness and Poverty (NLCHP) which states that approximately 3.5 million people, 1.35 million of them children, are likely to experience homelessness in a given year (NLCHP, 2007). At the 2008 U.S. Conference of Mayors an increase in homelessness was reported, attributed to rising foreclosure rates (2008 Status Report on Hunger & Homelessness).

In an effort to have a more accurate count of the homeless population the U.S. Department of Housing and Urban Development (HUD) developed a data collection system (HUD's Annual Homeless Assessment Report [AHAR], 2009). Based on the Homelessness Management Information Systems (HMIS) data provided by the national AHAR sample, more than 1,150,000 total persons used emergency shelter and/or transitional housing nationwide from January through June 2006. Later AHARs included persons who were served only in domestic violence shelters due to identity protection laws, and those in the U.S. Territories or the Commonwealth of Puerto Rico. Since tracking began, the total numbers of homeless people have declined slightly. On a single night, there were 643,067 sheltered and unsheltered homeless people nationwide in 2009 (HUD, 2009), as compared to 610,042 people in January 2013 (HUD, 2013). The relative ratio of homeless people unsheltered versus sheltered has also declined slightly, with a rule of thumb of approximately 65 percent of homeless staying in some kind of shelter fit for human habitation.

Trends in Sheltered Population of Homeless

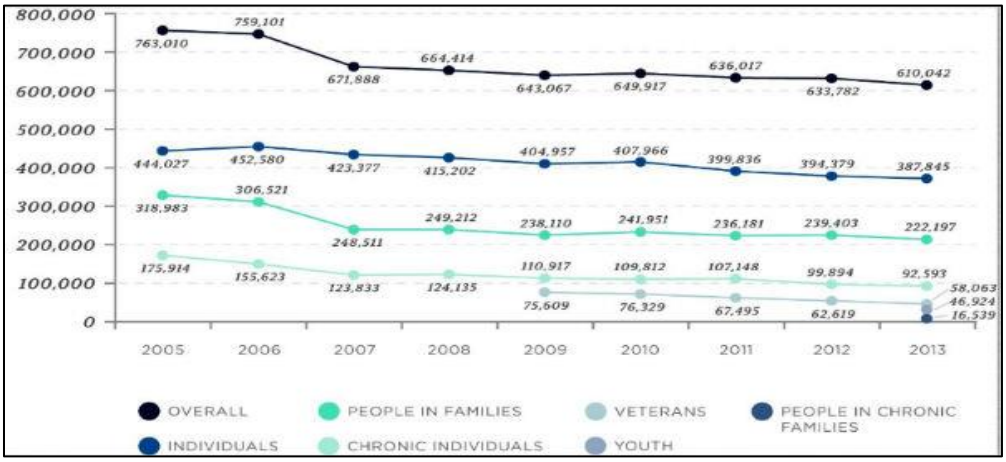
These patterns continue, with a few exceptions. In 2010 the statistics show family use of shelters has increased (Institute for Children, Poverty and Homelessness, 2011). In a January 2013 point-in-time estimate, there were 222,197 homeless people in families—36 percent of all homeless people (and 50 percent of people living in sheltered locations) (HUD, 2013).

Potential Causes of Homelessness

While there are many potential causes of homelessness, most fall into four subpopulations: domestic violence and poverty/unemployment (acute) and substance abuse and injury/illness (chronic) (Table 2). This model focuses on the root causes of homelessness, meaning that while there may be many contributing factors, there tends to be one predominant driver - either

overwhelming economic problems or overwhelming personal problems. The problems are either acute (if remediated, they can be temporary) or chronic (disability or repeated use, often difficult to resolve) (National Alliance to End Homelessness, 2013).

TABLE 2: TRENDS IN SHELTERED HOMELESS SUBPOPULATIONS 2005-2013



Source: 2005-2013 Continuum of Care Applications

Acute Conditions

Unemployment and poverty

One of the most direct causes of unemployment is the lack of a stable job. According to the Committee to End Homelessness, half of homeless adults make less than $300 per month. Unemployment can itself be caused by a number of factors, including a lack of jobs, a lack of marketable job skills and a lack of the resources necessary to secure and maintain steady work. When a homeless adult loses a job this may lead to poverty for a family.

Domestic violence

Domestic violence is one of the main contributors to homelessness, with many homeless people turning to the streets to flee a violent home life. According to the homeless services agency, Camillus House (2008), domestic violence is the second leading cause of homelessness among women. However, domestic violence can also contribute to homelessness among children who suffer from physical, psychological or sexual abuse, as well as among abused elderly and handicapped (Homeless Resource Center, 2006).

Chronic Conditions

A significant proportion of the sheltered homeless population is disabled. Sheltered homeless adults are more than twice as likely to have a disability when compared to the general U.S. population. Approximately 38 percent of adults who used a shelter between January 1 and June 30, 2006 had a disabling condition compared to 30 percent of the poverty population and 17 percent of the total U.S. population (U.S. Department of HUD, 2007).

Mental illnesses often prevent individuals from taking the steps necessary to secure appropriate housing, including holding a steady job. According to a survey by the U.S. Conference of Mayors, approximately 22 percent of single homeless adults suffer from a severe and persistent mental illness (U.S. Conference of Mayors, 2008).

Substance abuse

While statistics about addiction as a cause of homelessness are less certain, according to the Seattle-based Committee to End Homelessness, addiction plays a role in the status of many chronically homeless individuals ("Causes", para 4). For example, in Connecticut almost one out of five (18 percent) of the 423 homeless parents participating in a point-in-time survey in 2009 were chronically homeless, defined as disabled and either continuously homeless for over one year or having experienced at least four episodes of homelessness in the past three years. Seventeen percent of all homeless parents have been hospitalized for mental health issue, 17 percent have received treatment for substance abuse and 18 percent currently experience health conditions that limit their ability to work or achieve self-sufficiency. Parents have been diagnosed with HIV/AIDS at a much lower rate (5 percent). Data on co-occurring health conditions are not available (Hartford Commission to End Homelessness, 2007).

TRENDS IN HOMELESS REMEDIATION

Over the last decade, federal homelessness policy shifted its focus to ending chronic homelessness. With newly earmarked federal funding, states were encouraged to develop ten-year plans to address the needs of this population. These new priorities reflect research that many individuals and families become homeless because they simply lack the money to afford a suitable residence. According to Camillus House (2008), in 1995, there were 4.4 million fewer available units of low-income housing than households in need of such residences. In a survey of 25 major U.S. cities, the cities surveyed cited unaffordable housing as the leading cause of homeless among families (U.S. Conference of Mayors, 2008). For example, in Connecticut, three-quarters (74 percent) of the homeless adults lost their homes in 2010 due to economic factors, such as rent difficulties, eviction, or foreclosure, and three-quarters (75 percent) were unemployed at the time of the count. Nearly half (46 percent) had never previously experienced

homelessness, two-thirds (68percent) had completed at least high school, and over half (61 percent) reported no mental health, substance abuse or long-term medical issues (Connecticut Coalition to End Homelessness, 2010*).* Prioritizing rapid rehousing heads off a host of ills that accompany long-term homelessness. Making housing stability the center of a homelessness system helps bring other mainstream resources to bear, including benefits and cash assistance, supportive services, housing assistance, health care, job training, and food and nutrition services (National Alliance to End Homelessness, 2009). For example, in Connecticut public assistance is essential. Connecticut is the sixth most expensive state for rental housing in the country and the fourth most expensive state for rental housing in non-metropolitan areas, (National Low Income Housing Coalition, 2011).

In an effort to accomplish the goal of reducing homelessness HUD's Homelessness Prevention and Rapid Re-Housing Program (HPRP) provides assistance to facilitate this transformation. HPRP has developed "best practice" strategies for current shelter providers: to (a) prevent the imminent loss of housing and (b) minimize shelter time in favor of, rapid re-housing, and quickly transition to self-sufficient living including:

1. Create a uniform process for targeting assistance.
2. Create a common set of performance measures for programs.
3. Create a system of oversight that encourages better individual and system wide program outcomes.
4. Coordinate homelessness assistance with mainstream resources from other programs and agencies (National Alliance to End Homelessness, 2009).

These new priorities have seriously impacted certain subpopulations. While long-term homeless single adults with a mental illness or substance abuse received unprecedented attention, homeless families with children were overlooked. Not surprisingly, the number of sheltered and unsheltered chronically homeless singles dropped between 2008 and 2010 (by 11.5 percent to 109,920), while that of sheltered persons in homeless families continued to increase (by 5.2 percent to 190,995) (ICPH, 2011).

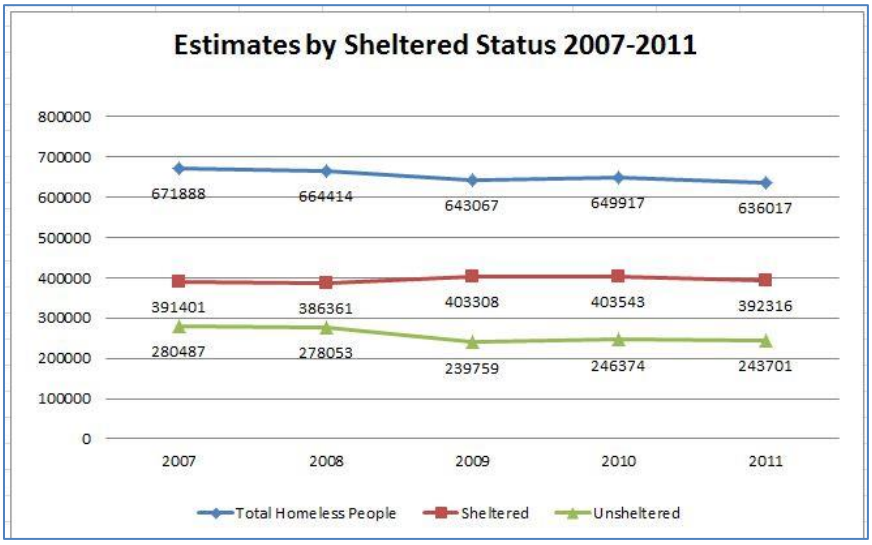
Recently released U.S. Department of Housing and Urban Development (HUD, 2010) data show that this transformation of the homelessness services structure is already underway. The nation's year-round bed inventory for homeless families grew by 9.3percent (from 286,257 beds in 2008 to 312,815 in 2010), mainly due to a 24.5 percent expansion (of 18,772) in the number of permanent supportive housing beds. Meanwhile, 1,461 transitional housing beds were eliminated, representing a 1.3 percent decrease. In 2008, the largest share of the nation's bed capacity for families consisted of transitional housing beds (38.8 percent), followed by emergency shelter (34.5 percent) and permanent supportive housing beds (26.8 percent). In 2010, 30.5 percent (95,353) of beds fell into the permanent supportive housing category, while the share of transitional housing beds (35.0 percent or 109,512 total beds) declined.

Between 2008 and 2010, the largest number of states (20), primarily located in parts of the Midwest and across the Southwest, reduced their inventory of transitional housing beds and increased the number of permanent supportive housing beds available for families. Only five states went against the overall trend and enlarged their transitional housing bed capacity, while decreasing or not changing their permanent supportive housing bed stock. Seventeen states expanded their bed count in both categories, eight states eliminated beds of both types, and one state did not alter the number of beds for either group (U.S. Department of HUD Report to Congress, 2010).

Implications for Repositioning Homeless Shelters

Federal policy strongly influences which service models and homeless populations' communities focus on, primarily because of targeted funding for specific types of programs and projects (Table 3). The 2009 HEARTH Act significantly redirected available funding towards prevention and rapid re-housing. This focus moves to quickly stabilizing people in housing diminishes the chaos in their lives and enables programs to address their clients' longer-term service needs. Focusing on housing stability affords greater opportunity for the homelessness assistance and mainstream systems to succeed. Since its inception in 2009, approximately 900,000 people have been helped with the prevention services offered through the program. Of those people who have exited the program, "89 percent left to permanent housing" (U.S. Department of HUD Annual Report to Congress 2011). In time, this paradigm shift is intended to continue to produce a decline in homelessness individuals.

TABLE 3: ESTIMATES BY SHELTERED STATUS SOURCE: HUD



Declines in homeless families are more problematic. Due to the economic recession of 2008, there was an increase in acute homelessness representation of families with children. As a result,

the Homelessness Prevention and Repaid Re-Housing Program (HPRP) was put into place to provide homeless people into temporary housing until such time that they could relocate to permanent housing. As a result, the number of transitional housing beds available for families can be expected to decline even further. HUD's best practice of minimal stays in shelter and a swift transition to self-sufficient living in permanent housing overlooks a majority of families that require more time and supportive services to overcome barriers to financial independence, such as low educational attainment and lack of sufficient employment skills. Only time will tell if this policy shift away from transitional housing will ultimately benefit and reduce the number of homeless families (U.S. Department of HUD 2008, & HUD 2011*)*.

Given the shifts in resource allocation, strategic evolution is inevitable. ***Contractors*** with their low cost offerings will be in ascendance, provided the quality of their offerings does not slip to the point where they become ineffective. Given their focus on clientele with acute problems, particularly the newly homeless, who are relatively easy to service, this should not be difficult. ***Holistic, comprehensive state programs*** will remain in decline, unless they can empirically document how this more expensive differentiation approach is more effective. This case can be made for homeless with chronic problems, who are underserviced by contractors, but only if that sub-population makes real, measurable improvements due to those programs. Failing this, strategic drift towards another strategic focus or dissolution is inevitable. ***Focused service providers*** inhabit a reactive strategic niche which is difficult to sustain.

Their best value mantra rings true only so long as they are demonstrably more effective than low-cost contractors. This is difficult to do "on the cheap." However, as providers of token efforts for the chronic homeless, whose plight will be noticed, this strategic niche can be viable - providing external validation to government agencies in the interests of placating guilt and who need to maintain a positive public image. ***Targeted service providers*** have a viable and sustainable strategic focus, provided they select the right sub-population of the homeless to service. This sub-population must be in favor with HUD and/or with resource rich private funders. This strategy lives and dies on the basis of public perceptions of what type of homeless aid is perceived as popular and trendy.

FUTURE RESEARCH

Given that meaningful metrics of service effectiveness and quality are barely developing, this provider market is in a state of flux, which is likely to continue. Regardless of the emergent criteria, they will be controversial and subject to change, either from further financial exigencies or from shifts in public perception and support. Further research is clearly needed.

CONCLUSION

The federal government passed the HEARTH ACT that was signed into law in 2009. The U.S. Department of Housing and Urban Development (HUD) is the responsible government agency. The HUD business model is implemented nationally. It changed the paradigm for care for the homeless. HUD has deemed minimal stays in a shelter and a swift transition to self-sufficient living a "best practice". The current strategy for reducing homelessness is implementing homelessness prevention and rapid re-housing with funding away from the traditional concept. Although the commitment to end homelessness began in 2000 operational procedures needed to be developed and implemented in order to be effective.

In reviewing why one becomes homeless we have narrowed the business reason for homelessness to be either an acute or a chronic condition. The individual with the chronic condition may need several services. These services have typically been given by the Department of Social Services in the former business model. The individual with an acute condition may be a family needing housing and rental assistance because their home was foreclosed.

Housing availability is central to the success of this law. Cost of housing is an impediment that will require cities and towns to build additional permanent low cost housing units. If funding is cut for HUD's program to end homelessness the homeless will be at greater risk. In addition to serving the homeless by the established non-profit social service businesses, there are for profit competitors as well. The services that were provided by the non-profit providers from the Department of Social Services may be provided to the first time homeless persons by a for profit contractor. The for-profit competitor may reduce additional services however, provide housing meeting the overall objective of HUD's "best practice" to end homelessness. This changes the nature of strategic differentiation, and opens a new competitive arena being a low cost provider of the limited number of services deemed best practices by HUD. The first time homeless people who have acute, not chronic problems may be the market selected by the competition. The competitive for profit contractors will increase as government funding continues. The research for reducing homelessness in ten years needs to be documented for several years to track the results of the strategies that HUD has implemented to end homelessness and the resources needed to accomplish this business endeavor with positive social values for people and their community.

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