Homeless Service Delivery in the Context of Continuum of Care

Yin-Ling Irene Wong, PhD
Jung Min Park, PhD
Howard Nemon, PhD

ABSTRACT. Emergency shelters, transitional housing, and permanent supportive housing are distinct programmatic responses to address the housing and service needs of the homeless population under the Continuum of Care (CoC) model for homeless service delivery. Using organizational-level data collected from a multi-site survey of 300 homeless residential programs in 14 communities, this study examines the extent to which operationalization of these programs is in accordance with the CoC model. Findings suggest consistency with as well as deviation from the CoC model in the operationalization of homeless residential programs. Recommendations are provided for local community service planning and development that can assure effective delivery of services for meeting the needs of homeless people. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <http://www.HaworthPress.com>*

Yin-Ling Irene Wong is Associate Professor, School of Social Work, University of Pennsylvania, 3701 Locust Walk, Philadelphia, PA 19104-6214 (E-mail: iwong@ssw.upenn.edu). Jung Min Park is Research Assistant Professor, Center for Mental Health Policy and Services Research, University of Pennsylvania, 3535 Market Street, Philadelphia, PA 19104 (E-mail: minpark@mail.med.upenn.edu). Howard Nemon is Assistant Professor, Department of Social Work, George Mason University, 3330 North Washington Boulevard, MS 1F7, Arlington, VA 22201 (E-mail: hnemon@gmu.edu).

Administration in Social Work, Vol. 30(1) 2006
Available online at http://www.haworthpress.com/web/ASW

doi:10.1300/J147v30n01_05

KEYWORDS. Continuum of care, homeless service delivery, management practices, organizational analysis

INTRODUCTION

For decades since the recession of 1981-82 in the United States, homelessness has remained a significant social problem in the public policy arena. In contrast to homelessness before the 1980s,[1] the homeless population today constitutes a diverse group with people from various ethnic communities, single males and females, families with children, unaccompanied youths, and individuals with severe and persistent mental health and substance use problems (Shlay & Rossi, 1992). The increased heterogeneity of the homeless population has prompted public awareness of the need for an array of interventions providing services to various subgroups of homeless clients (Kuhn & Culhane, 1998; Mowbray, Bybee, & Cohen, 1993).

The evolution of public policy response represents an acknowledgment of the multifarious nature of homelessness. The earliest response to homelessness was ad hoc and crisis-oriented, and took the form of short-term emergency shelters and emergency food programs (Couzens, 1997). It was believed in the early 1980s that homelessness, as a major social problem, would be significantly contained with the end of recession and return of economic prosperity. The relentless nature of homelessness, however, shattered the hope of a short-term and ad hoc response. In response to the persistence of homelessness, Congress passed the McKinney-Vento Homeless Assistance Act in 1987, the first federal law to specifically address homelessness.[2]

The McKinney-Vento Act provides federal support for a variety of homeless service programs at the local level (U.S. Department of Housing and Urban Development [HUD], 2002). These service programs are expected to constitute a local multi-tier homeless assistance system, referred to as the Continuum of Care (CoC), in meeting the various needs of subgroups of homeless clients. Introduced in the mid-1990s, the CoC was designed to augment service coordination and integration at the local service system, as well as to improve access to services as homeless clients move from one tier of service to another in their transition to stable housing (Goodfellow & Parish, 2000; Interagency Council on the Homeless, 1994).

Central to the CoC model are three distinct programmatic responses to address the housing and service needs of the homeless population. These programmatic responses, namely, emergency shelter programs, transitional housing, and permanent supportive housing, correspond to a three-tier structure differenti-

ated by the degree of permanency of housing and service arrangements (Couzens, 1997).

Regarded as the point of entry into the CoC, emergency shelter programs (ESPs) are intended to provide short-term housing and services in order to meet the immediate needs of individuals and families confronted with an imminent loss of housing and of those who are already homeless. An emergency shelter can be considered a "catchall" program serving individuals with diverse needs, from transitionally homeless people with no or little behavioral or physical health problems to chronically homeless people with major functional disabilities (Kuhn & Culhane, 1998). Typically with a pre-designated length of stay policy, transitional housing programs (THPs) are designed to provide interim housing placement and supportive services for persons who are not ready for or do not have access to permanent housing. Transitional housing is considered to be service intensive and aims at promoting "housing readiness" through the provision of treatment and therapeutic services, as well as services enabling homeless clients to achieve self-sufficiency through housing assistance, case management, employment, and training. Finally, permanent supportive housing (PSHs) is targeted for individuals with functional disabilities so severe that continued maintenance of independent housing without support services is not feasible. Permanent supportive housing programs serve previously homeless individuals who have serious mental illness, chronic substance abuse problems, physical disabilities, or AIDS and related illnesses (HUD, 2002). Because support for PSH residents is likely to be long-term, staff of permanent supportive housing programs are expected to connect their residents to services available in the mainstream (i.e., non-homeless) service system in the community.

In summary, there has been significant growth in emergency shelter, transitional housing and permanent supportive housing programs since the passage of the McKinney-Vento Act. These three programs have indeed received the majority of federal funding authorized through the legislation. Yet despite their critical role in public policy and service delivery, prior research has not adequately examined the operation of these homeless residential programs in the context of the Continuum of Care model. The present study was designed to compare the organizational and service characteristics of these programs and to examine the extent to which operationalization of the three program concepts is consistent with the CoC model. As a result of this study, it is expected that major gaps in knowledge about the structure and practices of the homeless service delivery system in the U.S. will be addressed.

PREVIOUS RESEARCH ON CHARACTERISTICS OF HOMELESS RESIDENTIAL PROGRAMS

Between 1984 and 1996, three national sample surveys reported on the organizational and service characteristics of homeless residential programs (HUD, 1984; HUD, 1989; Interagency Council on the Homeless, 1999). Despite differences in sampling strategies, types of questions asked and methods of data collection used across the 1984, 1988, and 1995–6 surveys, comparison of study results provides useful information for understanding changes in the homeless service delivery system. Data concerning change in size and composition of the homeless residential system, funding sources and agencies operating homeless residential programs are reviewed for purposes of this study.

Estimates of the number of homeless residential programs nearly tripled in a four-year period between 1984 and 1988 (from 1,900 to 5,400) and more than doubled in an eight-year period between 1988 and 1996 (from 5,400 to 12,010). Correspondingly, bed capacity rose from 100,000 in 1984, 275,000 in 1988, to 582,000 in 1996. Of equal importance in the growth in size was the change in composition of residential program types. In both the 1984 and 1988 surveys, homeless residential programs were comprised primarily of overnight shelters. However, in the 1995–6 survey, only 47 percent (or 5,690 ESPs out of 12,010 programs) were ESPs. THPs and PSHs, the two program elements supported by the McKinney-Vento Act, represented 37 percent (4,400 THPs) and 16 percent (1,920 PSHs), respectively, of all residential service programs in 1996.

The growth in homeless residential programs was accompanied by a shift in funding patterns. Whereas nearly two-thirds (63%) of the 1983 operating expenses for all shelters came from private sources, two-thirds of the 1988 shelter revenues came from a variety of federal, state, and local government sources. In the 19950-1996 survey, an estimated 53 percent and 52 percent, respectively, of ESPs and THPs relied on government funding as the major source of revenue (defined as reporting the share of government funding to be 51% or more), and 74 percent of PSHs relied on government funding. There appears to be no change in the types of organizations that operated homeless residential programs. In all three surveys, private, not-for-profit organizations played a dominant role in operating these programs.

Program management practices and service provision were not examined in all three national sample surveys, so comparison over time was not available. The 1988 HUD survey did include some questions about management practices and found a majority of shelters required residents to receive counseling or casework and to perform chores around the facility. The survey also

found that only a small portion of the shelters (between 16% and 32%) provided treatment services such as substance abuse treatment, mental health care, and general health care; whereas, services meeting basic needs including transportation, food, and clothing were available to residents of most shelters (between 68% and 81%).

In contrast, a 1992 homeless family shelter survey of programs in the national database of the Better Homes Fund[3] reported that 90 percent and 80 percent, respectively, of shelters provided directly or indirectly (through referrals) substance abuse counseling and medical care for adults and children (Weinreb & Rossi, 1995). Interestingly, despite the availability of behavioral health services, the same study found that family programs had restrictive admissions policy with almost one-half rejecting clients with drug or alcohol problems and two in five programs rejecting clients with mental health problems. Behavioral compliance was also common among family shelters, with policies requiring residents to sign contracts that spelled out shelter rules and regulations, to perform housekeeping tasks, to refrain from potentially problem behavior such as use of alcohol and drugs, and to participate in counseling and programs.

Other family shelter surveys corroborated Weinreb and Rossi's findings. Barge and Norr's (1991) study reported restrictive screening and admission policies adopted by shelters serving women in Chicago. Specifically, THPs were found to have more stringent selection criteria than ESPs. Using a national sample of homeless family shelters with family support programs, Jacobs, Little, and Almeida (1993) documented the prevalent use of exclusion criteria for admission. The most common reasons for turning away homeless families cited in the study were active drug (86%) and alcohol (83%) use by a family member. Facility size was correlated with shelter policy; smaller shelters operated with a greater number of exclusion criteria and larger shelters had higher percentages of mandatory family programming. Jacobs et al.'s study also documented three common types of services provided in their sample–educational, supportive, and intervention/therapeutic services.

In addition to the surveys described above, a number of mixed-method and qualitative studies provided useful information about management practices and service provision of homeless residential programs. Based on a multimethod evaluation study of family homeless shelters in Westchester County, NY, it was concluded that requirements for residents to comply with program rules and regulations and an emphasis on treatment services inadvertently encouraged the "therapeutic incarceration" of homeless families in transitional housing facilities (Gerstel, Bogard, McConnell, & Schwartz, 1996). Specifically, the study found that service-intensive programs tended to impose more constraints on resident liberty. Rules and regulations in turn led to increased social isolation among homeless families and prolonged the length of stay in

shelters, resulting in an erosion of social support networks that shelter residents had previously used to avoid homelessness.

Several qualitative studies examined the ways through which management practices and shelter environment affect resident outcomes including exiting homelessness. Based on ongoing participant observation, Stark (1994) argued that mechanisms of control, including rules and regulations imposed by shelters, created barriers to return to economic self-sufficiency among shelter clients. A participant observation study in a large, barrack-type shelter in New York City found that forms of associations among shelter dwellers, emerged to circumvent shelter rules and regulations, might inadvertently limit possible trajectories out of homelessness (Dordick, 1996). A qualitative study based on on-site observation and documentary analysis of three THPs (Crook, 2001) concluded that programs with less bureaucratic control, greater indigenous participatory leadership, and more personalized approaches had residents reporting more positive experiences than programs with other organizational configurations.

RESEARCH QUESTIONS

Prior studies have documented remarkable programmatic growth in homeless residential programs, particularly in transitional housing and permanent supportive housing programs. Coupled with this growth has been an increased reliance on government funding for these programs. Research has also documented an increased focus on treatment services and a greater reliance on program rules and policies that restrict resident liberty. These changes were associated with adverse effects on the experiences and outcomes of homeless clients. However, previous research has not systematically compared the organizational and service characteristics among the three key residential program elements of the Continuum of Care. To address this knowledge gap, this study was designed to examine the following questions:

1. Are there differences in organizational and service characteristics of ESPs, THPs, and PSHs?
2. To what extent is the operationalization of ESPs, THPs, and PSHs consistent with their respective program concepts in the CoC model?

METHODS

Study Sites

The data analyzed came from the 2001 Survey of Homeless Service Providers (2001 HSP Survey). The 2001 HSP Survey was designed to collect data

from homeless service programs that reported into homeless management information systems (HMISs) of a sample of 15 U.S. jurisdictions. HMISs are networks of homeless service providers in a geographically-defined entity (or jurisdiction) that maintain centralized and automated data collection systems compiling information on homeless services and the persons who use them.

The 15 jurisdictions were selected because they had maintained an operating HMIS at the time of the study.[4] Eleven of the 15 jurisdictions (Metropolitan Boston, MA; Columbus, OH; Kansas City, MO; Montgomery County, MD; New York City, NY; Philadelphia, PA; State of Rhode Island; St. Louis County, MO; St. Paul, MN; Spokane, WA; Washington, DC) had 75 percent coverage of all emergency shelter beds in their respective HMIS, and four jurisdictions (Atlanta, GA; Grand Rapids, MI; Lafayette, IN; San Diego, CA) had less than 75 percent coverage.

Study Sample

A total of 641 homeless service programs were identified in the 15 jurisdictions. Five hundred and eighty-seven (587) surveys were completed and returned, resulting in an overall response rate of 92 percent. Four jurisdictions reported 100 percent response rate, six jurisdictions had a response rate of between 92 percent and 97 percent, and five jurisdictions had a response rate of less than 90 percent (85%–88%). Eighty-one percent (N = 473) of all surveyed programs were ESPs, THPs, or PSHs. Nineteen percent were other programs including non-residential supportive services programs, domestic violence shelters, and outreach programs. Among the 473 residential programs, 30 percent (N = 173) were from New York City. Because the New York City HMIS did not adopt the same definition of program type (i.e., definition of ESP and THP) as the other 14 jurisdictions did, residential programs in New York City were excluded from the analysis. The final sample (N = 300) included 153 ESPs, 124 THPs, and 23 PSHs. The Appendix shows the distribution of ESPs, THPs, and PSHs in 14 jurisdictions excluding New York City.

The majority (61%) of the 300 homeless residential programs were established after the McKinney-Vento Act (i.e., in 1988 or after). Only 46 percent of ESPs were established after 1987, compared to 73 percent of THPs and 96 percent of PSHs, suggesting the critical role of the McKinney-Vento Act in initiating and expanding transitional and permanent housing programs.

Survey Procedure and Content

The 2001 HSP Survey was a mail survey of homeless service programs that reported into the HMISs of the sampled jurisdictions. Site coordinators of the

jurisdictions distributed the surveys to program managers or staff persons who had a good working knowledge of the operation of homeless residential programs and their clients. The site coordinators were responsible for following up with each program in order to attain a response rate of 90 percent and for conducting data audit of completed surveys.

The survey questionnaire was developed by the first and third authors of this article. A draft questionnaire was presented at a national conference attended by managers of HMISs. Feedback was obtained from conference participants regarding the content and structure of the questionnaire, as well as wording of the questions. The questionnaire was further revised based on feedback from the chief consultant of the 1995-96 National Survey. A pretest of the survey questionnaire was conducted with 12 residential programs, including six ESPs, four THPs, and two PSHs. The questionnaire included forced-choice items on the following areas: (1) target populations and program operation; (2) staff patterns; (3) service provision; (4) physical and architectural features; (5) management practices; (6) program funding; and (7) background of agency operating the program.

Measurement and Scaling

Scoring for Level of Privacy Provided in Different Types of Accommodation. A composite score was created to measure the level of privacy afforded to program residents. Eleven different types of sleeping accommodation enumerated in the "physical and architectural features" section of the questionnaire were collapsed into four categories with higher scores indicating increased privacy: barrack and congregate housing (scored 1), shared bedroom (scored 2), shared apartment and own bedroom (scored 3), and single apartment or family home (scored 4). Because programs may have more than one category of accommodation, the score of the most private and the score of the least private accommodation available were added.[5]

Scales for Measuring Program Policies and Practices. The Policy and Service Characteristics Dimensions (PASCI), one of four sections in Residential Substance Abuse and Psychiatric Programs Inventory (RESPPI) developed by Timko and Moos (Moos, 1988; Timko, 1996), was included in the survey. The RESPPI is a multi-dimensional inventory designed to examine four sets of program characteristics, including physical and architectural features, policies and services, aggregate resident characteristics, and treatment or support climate. The RESPPI has been applied to the assessment of program environment of hospital-based and community-based residential programs in the fields of mental health, substance abuse, and gerontology (Moos & Lemke, 1994; Timko & Moos, 1998).

Specifically, three subscales of PASCI that assess the policies and practices of residential programs were included in the survey. These subscales were: (1) expectations for functioning in admissions of clients (9 items; alpha = 0.85); (2) acceptance of problem behavior (15 items; alpha = 0.83); and (3) resident participation (9 items; alpha = 0.64). For the 15-item acceptance of problem behavior scale, principal component analysis was used to identify distinct types of behavior.

Scale for Measuring Service Provision. A 16-item question enumerated an array of services provided by programs in the form of structured activities (alpha = 0.79). Principal components analysis was conducted to identify distinct types of services contained in the question.

Method of Data Analysis

Cross-tabulation and chi-square statistics were used for categorical variables. ANOVA tests were used to compare means for interval-level variables and composite scales. In analyses involving the ANOVA tests, post-hoc pairwise multiple comparisons were conducted in order to identify the difference between each pair of means for ESP, THP, and PSH.

RESULTS

Results on organizational and service characteristics were organized according to three topic areas: operational characteristics, management practices, and service provisions. For each topic area, an operational definition was given followed by the presentation of statistical findings.

Operational Characteristics

Operational characteristics are basic "demographic" features of a program that affect the organization and delivery of services to homeless people. Two types of operational characteristics were differentiated: features that define the organizational structure of a program (Table 1) and features that are central to the direct service delivery to homeless clients. Structural characteristics of a program include organizational type, program capacity, and financial basis of operations. Operational characteristics pertaining to direct service delivery include target population, policy regarding client's maximum length of stay, staffing, and physical features.

Characteristics Pertaining to Organizational Structure. The vast majority of homeless residential programs were operated by not-for-profit organiza-

TABLE 1. Operational Characteristics Pertaining to Organizational Structure[1]

	ESP		THP		PSH		Total	
Variable	*n (%)*	*M (SD)*	*n (%)*	*M (SD)*	*n (%)*	*M (SD)*	*N (%)*	*M (SD)*
Operating agencies (n = 291)								
Not-for-profit	126 (84.6)		109 (90.8)		18 (81.8)		253 (86.9)	
For-profit	11 (7.4)		3 (2.5)		1 (4.6)		15 (5.2)	
Other (including government)	12 (8.1)		8 (6.7)		3 (13.6)		23 (7.9)	
Religious affiliation (n = 300)								
Affiliated with a religious organization	62 (40.5)		39 (31.5)		5 (21.7)		106 (35.3)	
Program capacity (n=286)								
Number of beds***[a]		66.39 (65.21)		42.64 (43.03)		34.00 (65.16)		53.85 (58.09)
Budget in 000s								
Total budget* (n = 262)		$687.62 ($1,096.34)		$425.46 ($656.14)		$342.36 ($480.57)		$550.83 ($904.24)
Cost per bed (n = 255)		$14.05 ($17.93)		$13.10 ($10.02)		$11.58 ($10.42)		$13.47 ($14.50)
Number of funding sources (n = 264)								
Number of funding sources***[a]		1.26 (.49)		1.55 (.60)		1.54 (.51)		1.40 (.56)

Major sources of funding*** (n = 300)				
Federal funds	8 (5.2)	41 (33.1)	6 (26.1)	55 (18.3)
State funds	25 (16.3)	9 (7.3)	0 (0.0)	34 (11.3)
Local funds	40 (26.1)	15 (12.1)	2 (8.7)	57 (19.0)
Private funds	23 (15.0)	19 (15.3)	1 (4.3)	43 (14.3)
Other	12 (7.8)	7 (5.6)	4 (17.4)	23 (7.7)
No dominant patterns	20 (13.1)	24 (19.4)	9 (39.1)	53 (17.7)
N.A. (data unavailable)	25 (16.3)	10 (8.1)	1 (4.3)	36 (12.0)

Note:
[1]Sample size varies because of missing data for different questions.
***$p < .001$.
[a]ESP significantly different from THP and PSH. No difference between THP and PSH.

tions and less than 10 percent were operated by for-profit organizations (Table 1). A considerable number of homeless residential programs were affiliated with a religious organization. Specifically, 41 percent of ESPs, 32 percent of THPs, and 22 percent of PSHs were run by or sponsored by religious organizations.

The total number of beds from programs that provided program capacity information was as follows: 9,494 for ESPs (n = 143), 5,159 for THPs (n = 121), and 748 for PSHs (n = 22). As the data show, ESPs had the largest bed capacity with an average of 66 beds per program, followed by THPs with 43 beds and PSHs with 34 beds.

Given their program capacity, the average budget was largest for ESPs. However, when program size was factored in, no statistically significant difference was found in regard to the average cost per bed by program type.

Previous studies had found that homeless residential programs relied on a variety of funding sources to finance the types of services they offered to their clients (Weinreb & Rossi, 1995). In this study, we asked for the percentage of the program budget contributed by five different sources: federal government, state government, local government, private, and others. We examined the dominant funding source reported by programs, defined as a source that contributed at least 50 percent of the program's budget.

The ANOVA test results indicate that ESPs had on average less diverse sources of funding than THPs and PSHs. Using chi-square tests, this study also documents significant differences in the dominant funding sources for ESPs, THPs, and PSHs. Interestingly, despite the increased role of the federal government in funding homeless services, only five percent of ESPs reported that federal funds contributed to one-half or more of their program budget. The two most dominant funding sources for ESPs were from local government (26%) and state government (16%). This funding pattern of ESPs was different from both THPs and PSHs, which had 33 percent and 26 percent, respectively, of their programs relying on the federal government as the dominant funding source. Furthermore, comparing the percentage of programs that had dominant funding sources from government (combining federal, state, and local) vis-à-vis private funds suggests a limited role of private funding for homeless residential programs. Fifteen percent each of ESPs and THPs reported private funds as their dominant funding sources and only four percent of PSHs reported so, which compared to 47 percent of ESPs, 52 percent of THPs, and 35 percent of PSHs that reported either federal, state, or local government funds as their dominant financing source. Finally, it is important to note the portion of programs with no dominant pattern, defined as a condition when no single funding source contributed to 50 percent or more of the program's budget.

Two in five PSHs reported no dominant funding sources, compared to 19 percent of THPs and 13 percent of ESPs.

Characteristics Pertaining to Service Delivery. Table 2 shows the target population by household type. Interestingly, ESPs and THPs targeted similar populations. For both ESPs and THPs, close to 30 percent served families only and between 35 and 42 percent served single adults only. In contrast, the majority of PSHs (61%) were designed to serve single adults only.

There was an obvious difference among the three programs in regard to program policies on client's maximum length of stay. Consistent with the program's intent as an interim housing placement and its intensive service orientation, 81 percent of THPs allowed their clients to stay up to six to 24 months and only six percent had a maximum length of stay policy of less than six months. In contrast, ESPs had a less well-specified policy with 43 percent reporting either no formal policy regarding length of stay or imposing no stay limits on their clients. Less than two in five (38%) ESPs implemented a short-term stay policy of less than six months. One in five ESPs reported having a stay policy of up to six to 24 months, a policy considered to be characteristic of THPs. As expected, all PSHs in this survey imposed no length of stay limits for their residents.

The number of staff and the extent of training and experience of staff were considered to be factors pertinent for enhancing program effectiveness (Weinreb & Rossi, 1995). Among the three programs, ESPs had the largest number of staff with a mean of 13 employees. THPs and PSHs had a similar number of staff of around eight employees. Professional staff, including medical practitioners, counselors, and case managers, were distinguished from administrative staff and direct care workers. There was little difference in the average number of professional staff across the three programs. All the programs had on average three professional staff. The difference in total number of staff seems to have resulted from the disparity in the number of administrative staff and direct care workers in each program type, which varied according to the size of programs.

To compare service intensity, bed-staff ratios were computed. As the data indicate, there was no statistically significant difference in bed-staff ratios across programs. ESPs had on average four volunteers per program, compared to 2.4 volunteers THPs and less than one volunteer per program for PSHs.

Level of privacy, a physical feature considered to be critical to clients' quality of life, was indicated by the types of sleeping accommodation provided by the residential programs. As the data show, ESPs were less likely than THPs and PSHs to provide sleeping accommodation that afforded homeless clients with a high level of privacy. Indeed, 46 percent of ESPs offered barrack-type or congregate sleeping arrangements, compared to 13 percent of

TABLE 2. Operational Characteristics Pertaining to Service Delivery[1]

	ESP		THP		PSH		Total	
Variable	*n (%)*	*M (SD)*	*n (%)*	*M (SD)*	*n (%)*	*M (SD)*	*N (%)*	*M (SD)*
Target population (n = 292)								
Families only	42 (28.8)		35 (28.5)		3 (13.0)		80 (28.5)	
Single adults only	51 (34.9)		51 (41.5)		14 (60.9)		116 (39.7)	
Served more than 1 population group[2]	53 (36.3)		37 (32.9)		6 (26.1)		96 (32.9)	
Maximum length of stay policy (n = 300)								
Less than 6 months	58 (37.9)		7 (5.6)		0 (0.0)		65 (21.7)	
6 to 24 months	30 (19.6)		100 (80.7)		0 (0.0)		130 (43.3)	
No formal policy, no stay limits, permanent housing, other stay policy	65 (42.5)		17 (13.7)		23 (100.0)		105 (35.0)	
Staffing								
No. of employees***[a] (n = 300)		13.31 (13.71)		8.00 (7.79)		8.41 (12.73)		10.74 (11.81)
Bed-staff ratio (n = 279)		5.84 (4.96)		8.41 (17.11)		6.08 (5.33)		6.95 (11.79)
No. of volunteers (n = 295)		4.09 (5.02)		2.44 (3.80)		0.83 (1.37)		3.15 (4.46)

Level of privacy (n = 300)				
Barrack & congregate housing (%)***	70 (45.8)	16 (12.9)	0 (0.0)	86 (28.7)
Shared bedroom (%)	62 (40.5)	46 (37.1)	4 (17.4)	112 (37.3)
Shared apartment (%)	69 (45.1)	67 (54.0)	13 (56.5)	149 (49.7)
Single apartment & family home (%)***	15 (9.8)	46 (37.1)	12 (52.2)	73 (24.3)
Mean composite privacy score***[b]	4.13 (1.71)	5.82 (1.68)	6.57 (1.25)	5.02 (1.90)

Note:

[1]Sample size varies because of missing data for different questions.

[2]Population groups included couples without children & unaccompanied children.

***$p < .001$.

[a]ESP significantly different from THP and PSH. No difference between THP and PSH.

[b]PSH have significantly higher score than THP; THP have significantly higher score than ESP.

THPs and none of PSHs. Only 10 percent of ESPs provided single apartment or family home, while 37 percent of THPs and 52 percent of PSHs did so. The findings are consistent with those based on the composite score of the most private and the least private accommodation available in each program. The ANOVA test results suggest that PSHs provided the most individualized, private housing arrangements with a mean score of 6.6 and ESPs had the least private accommodations with a mean score of 4.1.

Management Practices

Management practices are indicated by program policies, rules, and regulations which restrict the types of individuals eligible for program participation, and which stipulate the standard of behavior permissible among program residents. Table 3 compares the admissions policies, various types of program requirements, acceptance of problem behavior, and resident participation across the three program types.

As the data show, homeless residential programs in the 14 jurisdictions were more restrictive in their admissions policies towards clients with psychiatric problems (including severe symptoms of mental illness and alcohol or illicit drug use) than clients with physical health problems (including serious physical illness and infectious diseases such as TB or HIV/AIDS). In addition, the vast majority of programs (89% of the 300 programs surveyed) did not accept clients who were considered to be a danger to self or to others. Across the three programs, THPs were most selective in their admissions policy for clients in all five areas, suggesting that THPs may admit clients with higher levels of functioning than those in ESPs and PSHs.

The survey examined three types of program requirements commonly adopted by homeless residential programs. These include requirement of an escrow so that clients could put aside a certain amount of money as savings for future use, a curfew policy such that clients were not allowed to come in after a certain time during the evening, and requirement of carrying out household chores as a condition to stay in the program. As the findings indicate, PSHs were less likely to impose restrictions on resident liberty than ESPs and THPs in all three measures. THPs were more likely to require household chores, whereas ESPs were more likely to have a curfew policy.

Table 3 shows the extent of acceptance for a list of problem behaviors. Program staff were asked to rate whether a certain behavior was allowed (coded 3), discouraged (coded 2), or intolerable (coded 1). A higher mean response indicates a higher level of acceptance, whereas a lower mean response indicates a lower level of acceptance. Factor analysis results suggest the 15-item scale to be grouped into four behavioral factors: (1) violent behavior, (2) non-

TABLE 3. Management Practices[1]

Variable	ESP		THP		PSH		Total	
	n (%)	*M (SD)*	*n (%)*	*M (SD)*	*n (%)*	*M (SD)*	*N (%)*	*M (SD)*
Admissions policy–programs not accepting (n = 300)								
Severe symptoms of mental illness***	66 (43.1)		83 (66.9)		11 (47.8)		160 (53.3)	
Alcohol/illicit drug use***	93 (60.8)		106 (85.5)		13 (56.5)		212 (70.7)	
Serious physical problems***	49 (32.0)		67 (54.0)		10 (43.5)		126 (42.0)	
Infectious disease**	41 (26.8)		48 (38.7)		2 (8.7)		91 (30.3)	
Danger to self or other*	130 (85.0)		117 (94.4)		20 (87.0)		267 (89.0)	
Program requirement								
Escrow (n = 295)	89 (58.9)		75 (61.0)		10 (47.6)		174 (59.0)	
Curfew*** (n = 281)	114 (79.7)		79 (67.5)		5 (23.8)		198 (70.5)	
Household chores* (n = 286)	100 (69.0)		95 (79.8)		12 (54.6)		207 (72.4)	
Acceptance of problem behavior–mean score (range: 1-3) (n = 299)								
Violent behavior***[a]		1.08 (.28)		1.06 (.21)		1.35 (.61)		1.09 (.30)
Noncompliance with rules restricting resident liberty***[a]		1.60 (.55)		1.82 (.63)		2.42 (.60)		1.75 (.62)
Noncompliance with program expectation***[a]		1.81 (.51)		1.68 (.40)		2.04 (.45)		1.78 (.47)
Self-destructive behavior*[a]		1.44 (.52)		1.57 (.57)		1.74 (.50)		1.52 (.54)

TABLE 3 (continued)

	ESP		THP		PSH		Total	
Variable	*n (%)*	*M (SD)*	*n (%)*	*M (SD)*	*n (%)*	*M (SD)*	*N (%)*	*M (SD)*
Resident participation (n = 300)								
Current or former clients hired as staff (%)**	93 (60.8)		61 (49.2)		6 (26.1)		160 (53.3)	
Have residents' council or committee (%)**	49 (32.0)		66 (53.2)		12 (52.2)		127 (42.3)	
Have community or resident meetings (%)*	120 (78.4)		111 (89.5)		19 (82.6)		250 (83.3)	

Note:
[1]Sample size varies because of missing data for different questions.
*$p < .05$, **$p < .01$, ***$p < .001$.
[a]PSH significantly different from ESP and THP. No difference between ESP and THP.

compliance with rules restricting resident liberty, (3) noncompliance with program expectation, and (4) self-destructive behavior.[6] Most behaviors elicited in the survey were rated as either "intolerable" or "discouraged." Violent behaviors were strictly prohibited, whereas programs were more accepting regarding noncompliant behavior on program rules and program expectations. Across all four problem behavior factors, ANOVA tests with post-hoc pairwise comparison of means suggest that PSHs had a higher level of acceptance than ESPs and THPs. There was no statistically significant difference between ESPs and THPs regarding the extent of acceptance for problem behavior for all four factors.

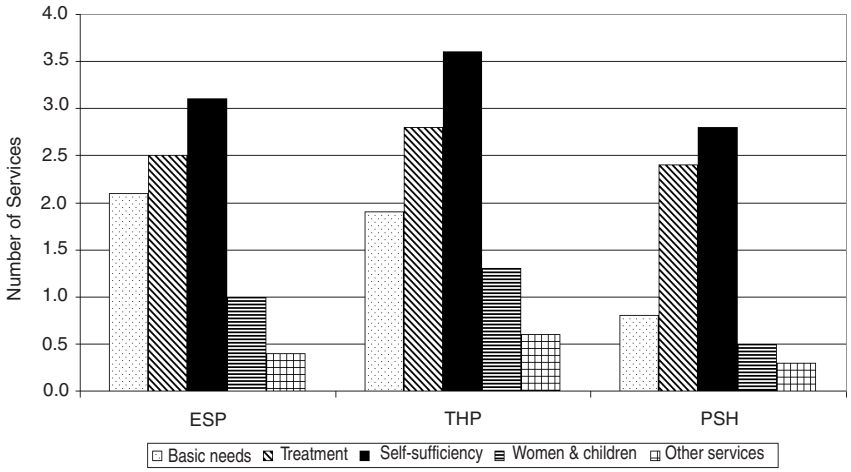
Resident participation, measured by different participatory structures instituted in the programs, may increase client satisfaction while they were staying in homeless residential programs. Our findings indicate that 61 percent of ESPs had either current or former clients working as paid staff in the program, compared to 49 percent of THPs and only 26 percent of PSHs. However, ESPs were less likely than THPs and PSHs to provide a channel (such as residents' council or committees) through which residents could raise their concerns or give their opinions about program policies and operation. Finally, the majority of the three programs had regular community meetings for clients or resident alumni meetings in place at the time of the survey.

Service Provision

Factor analysis results found five distinct domains of services offered by homeless residential programs: (1) services meeting basic needs including food, clothing and transportation; (2) treatment services including general health care, substance abuse treatment, mental health treatment, and prevention and treatment of HIV/AIDS; (3) services promoting self-sufficiency including life skills training, case management, housing assistance, and employment services; (4) services for women and children including education, child care, and domestic violence counseling; and (5) other services including legal assistance and veteran services. All service variables with the exception of transportation have a minimum factor loading of .50.

Figure 1 compares the mean number of services offered in each of the five service domains. Significant differences were found across the three programs in services meeting basic needs, services promoting self-sufficiency, services for women and children, and other services. No difference was found in the number of treatment services provided among ESPs, THPs, and PSHs. ANOVA post-hoc tests were conducted to identify the differences between each pair of means. Results show that: (1) PSHs offered less services for basic needs than THPs and ESPs; (2) THPs offered more services promoting self-sufficiency

FIGURE 1. Mean Number of Services Provided



than PSHs and ESPs; (3) PSHs offered less services for women and family than ESPs and THPs; and (4) THPs offered more other services than ESPs and PSHs. Overall, PSHs offered significantly less services than the other two programs, while there was no statistically significant difference between ESPs and THPs in the total number of services provided.

DISCUSSION

The CoC model, as initially conceptualized, was intended to coordinate service delivery at the local level in order to respond to the physical, economic, social and medical needs of the homeless population (HUD, 1995). Although this model has been widely accepted among homeless service providers, there is insufficient evidence for determining how well it is being implemented. By examining a sample of 300 homeless service programs located in 14 jurisdictions, this study greatly enhances information available concerning implementation and operationalization of the Continuum of Care model.

The research findings indicate that, to a certain extent, the structure and activities of these programs were consistent with the intended missions and objectives of the CoC model. As initial points-of-entry for all types of homeless people, ESPs were significantly larger in terms of bed capacity and maintained

over 50 percent more employees than the other two programs. True to their purpose of providing emergency housing, their housing features manifested significantly lower level of privacy, with nearly half of ESP facilities having barrack-type or congregate housing. Also, only about a third of the ESPs provided residents with opportunities to participate on shelter councils or committees, probably due to the short-term nature of resident stay in the shelter.

The THPs in the study's sample adhered to a length of stay policy typical of these programs, with over 80 percent establishing a 6-24 month limit on resident occupancy. They also offered a wide range of services, with an emphasis on services promoting self-sufficiency through life skills training, case management, housing assistance, and employment services. This is consistent with their program mission of preparing residents to achieve permanent housing.

The survey results also reveal some predictable characteristics of PSHs. As permanent housing programs, they did not enforce limits on length of stay, demanded less from their residents in terms of program requirements such as escrows or curfews, and generally provided more privacy than the other two programs. Moreover, responding to the needs of a resident population with severe functional disabilities, PSHs were significantly more accepting of all types of problem behavior than ESPs and THPs.

Despite the aforementioned concordances between the operationalization of the sampled ESPs, THPs, and PSHs and their respective program concepts, there were aspects of implementation that seemed to deviate from the CoC model. For example, the length of stay policies for the ESPs were somewhat erratic, with only 38 percent of the shelters enforcing a stay limit of less than six months and over 40 percent reporting no formal policy. By offering longer stay periods, the ESPs were no longer fulfilling their "emergency" role in the homeless service delivery system. Indeed, the longer stay policy might reflect the inability of some ESPs to move their clients along the Continuum of Care in a timely fashion, suggesting administrative difficulties for enforcing a limited length of stay and the unavailability of housing in other programs, such as THPs and PSHs, which would accept their residents.

The restrictive admissions policies of the ESPs also limited their ability to function as initial gateways to the homeless service delivery system. As the data indicate, 43 percent of the ESPs did not admit persons with severe symptoms of mental illness, 32 percent did not admit persons with serious physical problems, and 27 percent did not admit persons with infectious disease. Even more alarmingly, with a 61 percent rejection rate for those suffering from substance abuse–a prevalent condition among the homeless–the ESPs were prohibiting a significant portion of the homeless population from even entering the Continuum of Care. The exclusion of these populations from the shelter

programs echoed the results of both Weinreb and Rossi (1995) and Jacobs et al. (1993).

Deviation from the CoC model was also evident in the service characteristics and organizational behavior of THPs. Recall that the purpose of THPs was to provide interim housing and supportive services, including treatment services and self-sufficiency services, to those who need additional help in leaving homelessness. However, contrary to the expectation of a strong focus on treatment services for THPs relative to ESPs and PSHs, this study did not document any difference in the number of these services offered by the three programs. Nevertheless, THPs did provide significantly more self-sufficiency services than the other two programs.

Consistent with the observations of Barge and Norr (1991), THPs in this study were more restrictive in their admissions policies than the other two programs. Limiting admissions for those with extreme physical or mental disabilities might be understandable, as a certain level of functioning is required to take advantage of transitional housing. Yet the findings that 86 percent of THPs in the study excluded individuals with substance abuse problem and that almost 40 percent of THPs excluded those with infectious diseases begged the question of whether these facilities were in fact "creaming off" the best-functioning individuals among the homeless, while denying critical services to those most in need for service-rich housing placements.

Analysis of other aspects of THPs' management practices confirmed findings from previous studies documenting stringent program rules and regulations posed by homeless programs in restricting resident liberty (Gerstel et al., 1996; Stark, 1994). This study found that THPs and ESPs did not differ in the extent of acceptance of problem behavior. Interestingly, PSHs imposed less restrictive rules than the other two programs. Previous research had found that stringent management practices may actually hinder resident efforts to leave the programs and achieve stable housing. Restrictive environments tended to increase resident dependency upon the program and limit the residents' access to outside opportunities and resources. Specific to THPs, such practices could be counterproductive to the program goal they strive to attain–that is, fostering economic independence and stability.

Although the characteristics of PSHs were generally consistent with their function in the CoC model, our survey data did reveal some possible problems in accessing these programs. Although PSHs were more likely to admit homeless people with functional disabilities than ESPs and THPs, as evidenced by their application of more lenient admissions policies, the rejection rates for most of the special needs population categories were still in the range of 40 to 50 percent. If almost half of the PSHs reported not accepting homeless persons

with severe symptoms of mental illness, it is reasonable to ask about the fate of those who were denied entry to permanent housing with support services. The presence of such a service gap illustrates the potential barriers that homeless people with disabilities may experience in their endeavor to reintegrate into society.

LIMITATIONS OF THE STUDY

Given our research objectives, there are several identifiable problems with the data used in this study. Although the survey yielded an overall response rate of 92 percent, the fact that homeless residential programs were drawn from a limited number of jurisdictions, and from only those jurisdictions that had an operating homeless management information system, limits the generalizability of the findings. It is possible that programs in the sampled jurisdictions were different from those programs in communities not included in the study. Additionally, compared to ESPs and THPs, the generalizability of findings regarding PSHs may be compromised by its small sample size and by having had most of its sample members drawn from one jurisdiction, that is, from the Washington, DC area. It should be noted that most HMISs in the sampled jurisdictions did not include PSHs in their databases, although PSHs were an essential component of the CoC in these jurisdictions. PSHs are often administered by other specialized service delivery systems, such as the mental health system, drug and alcohol abuse treatment system, and HIV/AIDS services coordinating system, rather than by the homeless service delivery system.

IMPLICATIONS

Homeless people confront diverse and often compounded challenges. The CoC model of service delivery presupposes a system of coordinated programs and was designed to address the differential needs of this population with an assortment of programs and services. Results from this study reconfirm HUD's 1995 analysis that homeless programs did not yet operate as a "locally designed, comprehensive, flexible, coordinated system of homeless assistance" (p. 8). In order to more fully realize the benefits of the CoC model, a fine-tuning of existing ESPs, THPs, and PSHs is required. Specifically, this study highlights the need for improvements in the following two areas.

Admission and Referral Policies

Admission restrictions for prevalent groups in the homeless population, such as those with severe mental illness or substance abuse problems, could prevent many homeless people from accessing services. Programs for the homeless, especially the ESPs and THPs, need to relax their admission policies so that those with greater needs are not left without assistance. In order to broaden admissions without overburdening the CoC programs, better screening and referral systems need to be instituted. These organizational procedures would ensure more expediency regarding the placement of residents in programs that better meet their service needs. Hence, instead of having ESPs with erratic stay periods, residents qualifying for other programs could be expeditiously identified and placed in THPs or PSHs that adopt more open admissions policies.

Effective referral systems also entail better networking with community services outside the homeless service delivery system. Operating at the local level, the CoC model should be able to connect homeless clients to existing community-based organizations in other specialized service systems such as the behavioral health system and the service system assisting people living with HIV/AIDS. This would offer residents more options as well as reduce the pressure on the three programs to provide multiple services. As a result, currently excluded populations, such as those who are dangerous to themselves or others, could receive housing assistance from the homeless programs together with other types of treatment services available in the community. The PSHs, which directly provided the least number of services in spite of working with people with chronic disabilities, demonstrate the possibilities of such a referral system.

Program Requirements

Notwithstanding their responsibility to attend to the multiple needs of their residents, CoC programs must remain focused on the goal of permanent housing. As noted in previous research (Dordick, 1996; Gerstel et al., 1996; Stark, 1994), management practices that obliged residents to comply with an assortment of rules and regulations may hinder their efforts to overcome homelessness. The large number of treatment services in these programs, especially in the ESPs and THPs, might also contribute to prioritizing problems that are secondary to housing. Homeless programs need to develop a coherent set of rules and services that maximize the capacity and opportunities of the residents for achieving housing stability. Towards this end, referrals to outside services would allow residents to enhance their support networks in the community and facilitate their return to self-sufficiency.

Through changes in admissions, referral, and program requirements, the three components of the CoC could become more efficient in enabling their residents to access appropriate services. Implicit in this system is the existence of a coordinating structure at the local level, either public or private, that is responsible for overseeing homeless assistance programs and that expands its purview to other service systems. According to local housing needs, these coordinating agencies need to ensure an adequate number of ESPs, THPs, and PSHs, develop effective referral systems between them, and link them with service networks in the community. Although this study did not examine this aspect of the CoC model, these agencies obviously play a critical role in maintaining an integrated and comprehensive system capable of meeting the diverse needs of homeless people.

CONCLUSION

Over the last 20 years, there has been significant progress towards a more diversified and responsive homeless service delivery system. This study examines the characteristics of homeless residential programs in the context of the design and intent of the Continuum of Care. Findings of this study suggest that certain modifications in the operational characteristics, management practices, and service provisions could enhance the effectiveness of the three program types and their operation as an integrated service system. Building on these findings, future studies need to compare program administration with resident outcomes, such as the correlation between treatment modalities and leaving homelessness, in order to determine which aspects of the programs are more conducive to achieving stable housing. Greater knowledge is also required about how these programs operate as integrated and comprehensive systems. By selecting the local CoC as their unit of analysis, researchers could examine the relationship between programs, available community services, and local coordinating agencies. Such applied research would certainly improve how local Continuums of Care operate, thereby reducing costs, streamlining programs, and most importantly, hastening the transition out of homelessness.

NOTES

1. Prior research found that the homeless population in the three decades before the 1980s was composed primarily of white, middle-aged to older single males who were disaffiliated from mainstream society (Bahr & Caplow, 1974).

2. The McKinney-Vento Homeless Assistance Act of 1987 (PL 100-77) contained nine titles providing more than 20 grant assistance programs to fund emergency shel-

ters, transitional and supportive housing, emergency food, health-care, and mental health services, alcohol and drug abuse treatment, education, and job training (Interagency Council on the Homeless, 1994).

3. The Better Homes Fund, based in Newton Center, Massachusetts, was a national non-profit organization devoted to research and action on homeless families (Weinreb & Rossi, 1995, p. 90).

4. In 1999, it was estimated about 50 jurisdictions in the U.S. operated or were implementing an HMIS.

5. For example, a program that has shared bedrooms, shared apartments and apartments for each individual or family has a score of 6 (2 + 4). A program with barrack type of housing only has a score of 2 (1 + 1).

6. The "violent behavior" factor includes (1) damaging or destroying property; (2) engaging in physical assault; (3) engaging in sexual assault; and (4) verbally threatening a staff member. The "noncompliance with rules restricting resident liberty" factor includes (1) leaving the building during the evening without letting anyone know; (2) walking around the building or grounds at night; (3) engaging in sexual activity with a visiting spouse or partner; and (4) engaging in sexual activity with other clients. The "noncompliance with program expectation" factor includes (1) refusing to participate in programmed activities; (2) disrupting therapy sessions, community meetings or other organized group activities; (3) refusing to bathe or clean oneself regularly; and (4) refusing to take prescribed medication. The "self-destructive behavior" factor includes (1) threatening to attempt suicide and (2) engaging in other self-destructive behaviors. One item, "making sexually suggestive remarks or gestures," loaded on two factors ("noncompliance with rules restricting resident liberty" and "self-destructive behavior"). The item was excluded in the analysis.

REFERENCES

Bahr, H. M., & Caplow, T. (1974). *Old men drunk and sober*. New York: New York University Press.

Barge, F. C., & Norr, K. F. (1991). Homeless shelter policies for women in an urban environment. *IMAGE: Journal of Nursing Scholarship*, *23*(3), 145-149.

Couzens, S. E. (1997). Priority: Home! A true priority? An analysis of the federal plan to break the cycle of homelessness. *Journal of Social Distress and the Homeless*, *6*(4), 275-282.

Crook, W. P. (2001). Trickle-down bureaucracy: Does the organization affect client responses to programs? *Administration in Social Work*, *26*(1), 37-59.

Dordick, G. A. (1996). More than refuge: The social world of a homeless shelter. *Journal of Contemporary Ethnography*, *24*(4), 373-404.

Gerstel, N., Bogard, C., McConnell, J. J., & Schwartz, M. (1996). The therapeutic incarceration of homeless families. *Social Service Review*, *70*(4), 543-572.

Goodfellow, M., & Parish, K. (2000). Continuum of Care for the rural homeless: Examination of three cases. *Sociological Viewpoint*, *16*, 32-45.

Interagency Council on the Homeless (1994). *Priority: Home! The federal plan to break the cycle of homelessness*. Washington, DC: Interagency Council on the Homeless.

Interagency Council on the Homeless (1999). *Homelessness: Programs and the people they serve*. Washington, DC: U.S. Department of Housing and Urban Development.

Jacobs, F., Little, P., & Almeida, C. (1993). Supporting family life: A survey of homeless shelters. *Journal of Social Distress and the Homeless*, *2*(4), 269-288.

Kuhn, R., & Culhane, D. P. (1998). Applying cluster analysis to test a typology of homelessness by pattern of shelter utilization: Results from the analysis of administrative data. *American Journal of Community Psychology*, *26*(2), 207-232.

Moos, R. H. (1988). *Community-Oriented Programs Environment Scale manual* (2nd Ed.). Palo Alto, CA: Mind Garden.

Moos, R. H., & Lemke, S. (1994). *Group residences for older adults: Physical features, policies, and social climate*. New York: Oxford University Press.

Mowbray, C. T., Bybee, D., & Cohen, E. (1993). Describing the homeless mentally ill: Cluster analysis results. *American Journal of Community Psychology*, *21*(1), 67-93.

Shlay, A. B., & Rossi, P. H. (1992). Social science research and contemporary studies of homelessness. *Annual Review of Sociology*, *18*, 129-160.

Stark, L. R. (1994). The shelter as "total institution": An organizational barrier to remedying homelessness. *American Behavioral Scientist*, *37*(4), 553-562.

Timko, C. (1996). Physical characteristics of residential psychiatric and substance abuse programs: Organizational determinants and patient outcomes. *American Journal of Community Psychology*, *24*(1), 173-192.

Timko, C., & Moos, R. H. (1998). Determinants of the treatment climate in psychiatric and substance abuse programs: Implications for improving patient outcomes. *The Journal of Nervous & Mental Disease*, *186*, 96-103.

U.S. Department of Housing and Urban Development (1984). *A report to the secretary on the homeless and emergency shelters*. Washington, DC: Office of Policy Development and Research, HUD.

U.S. Department of Housing and Urban Development (1989). *A report on the 1988 National Survey of Shelters for the Homeless*. Washington, DC: Office of Policy Development and Research, HUD.

U.S. Department of Housing and Urban Development Office of Policy Development and Research (1995). *Review of Stewart B. McKinney homeless programs administered by HUD: Report to Congress*. Washington, DC: U.S. Department of Housing and Urban Development.

U.S. Department of Housing and Urban Development Office of Policy Development and Research (2002). *Evaluation of continuums of care for homeless people*. Rockville, MD: U.S. Department of Housing and Urban Development.

Weinreb, L., & Rossi, P. H. (1995). The American homeless family shelter "system." *Social Service Review*, *69*(1), 86-107.

APPENDIX. Distribution of the Study Sample

	ESP		THP		PSH		Total	
Jurisdiction	*n*	%	*n*	%	*n*	%	*N*	%
Atlanta, GA	6	3.9	10	8.1	0	0.0	16	5.3
Columbus, OH	11	7.2	2	1.6	0	0.0	13	4.3
Washington, DC	18	11.8	23	18.5	17	73.9	58	19.3
Grand Rapids, MI	9	5.9	7	5.6	0	0.0	16	5.3
Kansas City, MO	8	5.2	6	4.8	0	0.0	14	4.7
Lafayette, IN	1	0.7	2	1.6	0	0.0	3	1.0
Metropolitan Boston, MA	26	17.0	13	10.5	3	13.0	42	14.0
Montgomery County, MD	7	4.6	9	7.3	1	4.3	17	5.7
Philadelphia, PA	34	22.2	13	10.5	0	0.0	47	15.7
State of Rhode Island	13	8.5	1	0.8	0	0.0	14	4.7
San Diego, CA	0	0.0	10	8.1	1	4.3	11	3.7
Spokane, WA	6	3.9	11	8.9	1	4.3	18	6.0
St. Louis County, MO	7	4.6	6	4.8	0	0.0	13	4.3
St. Paul, MN	7	4.6	11	8.9	0	0.0	18	6.0
Total	153	100.0	124	100.0	23	100.0	300	100.0