INTRODUCTION

Homelessness is a social issue of immediate concern during the down economy. In 2009, roughly 1.56 million Americans throughout the country spent at least one night in an emergency shelter or transitional housing program (U.S. Department of Housing and Urban Development [HUD], 2010b). More than 6 million citizens were doubled-up with family and friends in the aftermath of 2.8 million foreclosures and a 60% increase in the unemployment of 14.3 million professionals and blue-collar workers (Sermons & Witte, 2011). Forty-seven (47) million citizens received supplementary food benefits. As a result, families were the fastest-growing sub-population in the homeless community. Alarmingly, 44% of people experiencing homelessness were gainfully employed. Contrary to popular belief, the majority of individuals experiencing homelessness were mentally stable, able-bodied men and women who simply could not afford to maintain housing on their own (HUD, 2010).

The selected community was located in a New England state ranked as one of the five hardest hit in the nation by the recent economic downturn (Rhode Island Housing, 2010). The state had the third highest unemployment rate at 12.7% (Reed, 2010) with a 10% drop in poor workers' income compared to the 2% national average. (Sermons & Witte, 2011). Moreover, the state had the highest rate of seriously delinquent mortgages in New England (Reed, 2010) and saw a 90% surge in its doubled-up population compared to an average 12% increase across the nation (Sermons & Witte, 2011). Given that doubled-up individuals—those living with family and friends for economic reasons—face the highest risk of becoming homeless, the state endured the third largest increase in its homeless population in the U.S. According to HUD (2009), from 2008 to 2009 its homeless population totaled 4,510 individuals in emergency shelters and transitional housing, including 905 single women and 1,706 adults and children in families.

The history of homelessness, its causes, and the emerging shelter movement are well documented (Closson, 1894; Dees, 1948; Hopper, 1990; Culhane, 1992; De Venanzi, 2008; DeWard & Moe, 2010). Nonetheless, little research examines the factors that influence length of stay in homeless shelters (Shinn, Knickman, Ward, Petrovic & Muth, 1990; Hartnett & Postmus, 2010; Weinreb, Rog, & Henderson, 2010). The literature on the power dynamics present in the staff-client interaction is even scarcer (Dees, 1948; Smith, 1977; Hopper, 1990; Walsh, et al., 2010; DeWard & Moe, 2010; Novotny, 2000) and only hints at their effects on length of stay. As such, this study examines the individual, environmental, organizational, and policy-level factors that influence shelter length of stay. Moreover, the analysis presents valuable insights into the power dynamics present in the homeless shelter staff-client interaction given the paucity of research in the literature on this subject.

LITERATURE REVIEW

DeWard and Moe (2010) elucidate how shelters tend to operate as total institutions whereby administrators and caseworkers assume sole rule-making, decision-making, and administrative power. Shelter planners traditionally view clients "more as problems than as capable of providing potential solutions" (Novotny, 2000, p.382) or as troubled individuals who are unable to function independently

(DeWard & Moe, 2010; Hopper, 1990). In order to receive shelter, residents must wholly submit to the set rules, practices, and decision-making of the staff, which systematically erodes their sense of autonomy, dignity, and pride. Challenging the institution only leads to punishment. The rules and the arbitrary enforcement of the rules essentially "exert control over residents and reinforce hierarchy (DeWard & Moe, 2010, p.119)."

DeWard and Moe (2010) conclude that residents find it impossible to simultaneously be a compliant dependent and achieve the self-sufficiency necessary to return to independent living. Yet, the researchers do not examine the underlying power bases and their impending effect on clients' length of stay. Likewise, Hopper (1990) only skims the surface with the assertion that shelter policies inhibit shelter consumers' "capacity and willingness… to return to work (p. 27)" but stops short of expounding on the power factors fueling the staff's actions in carrying out those policies.

Power and Influence in Staff-Client Relationships

Social power is defined in terms of the bases of power that shelter staff use to influence change in the client who is in a dependent position (Raven 2008; Gupta & Sharma, 2008; Pierro, Cicero, & Raven, 2008; Mossholder, Kemery, Bennett, & Wesolowski, 1998). Rather than directly controlling the outcomes in the client's life, use of these power bases alters the client's mental, emotional, and perhaps spiritual state by controlling his or her level of engagement through the provision or withholding of resources and the administration of punishments (Brauer & Bourhis, 2006; Davenport & Early, 2010). The client's altered state then affects their decision-making and action-taking behaviors which result in certain outcomes. The six bases of power include informational, expert, referent, reward, coercive, and legitimate.

Shelter staff with informational power possess the information that clients do not have access to or which is unknown to them but is needed to produce a positive outcome for clients (Baldwin, Kiviniemi, & Snyder, 2009). Power lies in the staff's ability to control if, when, how much, and how accurately the information will be shared with the client (Miller, Salsberry, & Devin, 2009). As a result of gaining the new knowledge, the client internalizes the new perspective or change in behavior and independently applies that change in future decision-making without continued guidance from the staff (Pierro, Cicero & Raven, 2008; Raven 2008; Baldwin, Kiviniemi, & Snyder, 2009).

Expert power parallels informational power. However, clients behave according to the information received out of a belief that the staff knows best (Gabel, 2011) but not because they understand or internalize a change in attitude (Raven, 2008). Staff with referent power possess the ability to inspire clients such that clients view them as a model to follow (Gabel, 2011; Raven, 2008).

Shelter staff who invoke reward power provide positive reinforcement, incentives, promises, concrete rewards, benefits, personal approval, respect, or autonomy when clients display a desired behavior. This type of power also entails the staff's ability to remove anything that is undesirable to the resident (Raven, 2008; Gabel, 2011; Mossholder, Kemery, Bennett, & Wesolowski, 1998). Conversely, coercive power employs threats (Rhode Island General Assembly, n.d.a, n.d.b, n.d.d), punishment,

negative consequences, undesirable conditions, or even personal disapproval to force residents to conform to an influence attempt. However, with both reward and coercive power, the change in a client's behavior remains dependent upon receiving the continued stimulus from the staff. The client does not internalize any new perspective or attitude that will prompt the behavior independently.

Legitimate power includes legitimate position power and legitimate power of responsibility or dependence (Raven, 2008; Pierro, Cicero & Raven, 2008). Legitimate position power encompasses a social norm or accepted hierarchical right for staff to require clients to accept or obey their demands and the clients' obligation to comply simply because the staff is in a superior position over the client (Gabel, 2011). On the other hand, legitimate power of responsibility or dependence – the power of the powerless (Raven, 2008) – necessitates that staff have the social responsibility to help clients who depend upon them for help because they are unable to help themselves.

Self-Advocacy as a Behavioral Response

This study attempts to evaluate clients' action-taking and decision-making responses to the homeless shelter staff in terms of self-advocacy. Self-advocacy comprises (i) knowledge of one's strengths, disabilities, rights, and responsibilities (Mishna, Muskat, Farnia, & Wiener, 2011; Kleinert, Harrison, Fisher, & Kleinert, 2010), (ii) the ability to make decisions and evaluate one's own behavior, and (iii) "the ability to effectively and appropriately communicate, convey, negotiate, or assert information" about one's strengths, choices, needs, required accommodations, rights, and responsibilities "to those with the ability to change the circumstances that contribute to the problem or inequity" (Clemens, Shipp, & Kimbel, 2011, p. 34).

Studies show that patients in a health and rehabilitation setting have greater success managing their illnesses when they advocate for themselves (Jonikas, et al., 2011). Conversely, patients who perceive an imbalance of power between themselves and their provider or who feel afraid to challenge their provider fail to advocate for themselves. Nonetheless, the literature is void of self-advocacy studies amongst people experiencing homelessness or residing in homeless shelters.

PURPOSE

Initially, the general purpose was to discover the unmet needs of families from vulnerable populations to inform program planning for the author's nonprofit organization. However, surprising incidents occurred between staff and clients in a homeless shelter during the first week of data collection. Thus, the purpose became two-fold: (i) to explore, describe, and critically interpret the lived experiences of individuals and families experiencing homelessness and (ii) to promote positive change in the policies and practices that uphold the discovered problems.

Problem Statement

The problem statement emerged throughout data collection. The problem was that, as a course of conduct, homeless service provider staff and security personnel (i) harassed, intimidated, and mentally

and verbally abused their homeless clients—as defined in the state's legal statutes—and (ii) administratively neglected their clients by failing to comply with organizational and federal policies.

Research Questions

The Homeless Emergency Assistance and Rapid Transition to Housing Act, or HEARTH, specifies "length of time homeless" (HUD, 2010a, p. 7) as one of the key performance indicators for Continuums of Care (CoC's) and related programs. High performing CoC's and programs have a mean length of homeless episodes that is less than 20 days (HUD, 2010a, p. 9). This study focused on:

RQ1. Is the typical length of stay for women in a homeless shelter program 30 days or less?

RQ2. What individual factors influence length of stay?

RQ3. What environmental factors influence length of stay?

RQ4. What organizational factors influence length of stay?

RQ5. What policy-level factors influence length of stay?

METHODOLOGY

The problem was investigated over a 29-week period from October 2010 to May 2011 using a critical, ethnographic research design. The author as principal investigator (PI) spent the first 40 nights in an emergency shelter operated by the largest provider of homeless services in the state (Provider A). She spent the remainder of the study in a Single Room Occupancy (SRO) transitional housing facility in a neighboring city operated by a different provider (Provider B). The PI achieved total situational immersion by interacting with providers and accessing services as would a person experiencing homelessness. The author received no research funding or private living stipend during the study.

Table 1: ***Client Characteristics in Provider A's 30-Day Operation First Step Program***

Client Code	Age	Race/Ethnicity	Marital Status	Children	Highest Ed	Employed	Entry Date
P1	23	Black, non-Hispanic	single	0	GED/HS	no	4/16/10
P2	34	Black, Hispanic	married	0	Vocational	no	6/16/10
P3	41	Hispanic	married	3	Vocational	during	7/1/10
P4	42	Native American	single	2	BA	no	8/1/10
P5	38	White	single	0	GED/HS	no	8/1/10
P6*	36	Black, non-Hispanic	single	0	MA	no	10/29/10
P7	54	White	divorced	3	Vocational	no	11/1/10
P8	29	African	married	0	BA	yes	11/11/10
P9	22	White	single	1	GED/HS	no	11/16/10

Note. *Client P6 is the PI.

Participants were selected using comprehensive sampling in Provider A's 30-Day Operation First Step program for women experiencing first-time homelessness. They ranged in age from 22 to 54 (n=9, *M*=35, *Mdn*=36, *SD*=10) as shown in Table 1. The majority were single (56%), unemployed (78%), Black or of African descent (44%), with no children (56%). One woman became employed during the study. The

racial makeup included Whites (33%), Hispanics (22%), and Native Americans (11%), with Client P2 being included in both the "Black" and "Hispanic" categories. Most had a GED or High school diploma (33%) or vocational certificate (33%). Two had bachelor's degrees and the PI (Client P6) held a master's degree.

Data were collected in two phases through covert participant observation, casual interviews, documents, and policy reviews. Phase I, the problem discovery phase, extended from October 2010 through February 2011. Phase II, the intervention phase (RQ5), began nine days after study start and ran concurrently until study end. For this phase, the author researched, drafted, and advocated for a comprehensive *Bill of Rights for the Homeless* as a policy-level intervention to free clients from what appeared to be systemic injustices in the homeless provider system. The study ended on May 14, 2011 after data collection for both phases reached saturation and the investigator returned to her home state in the South. However, advocacy efforts for a Homeless Bill of Rights continued post-study.

The PI examines RQ1, RQ2, RQ3, and RQ4 via descriptive and inferential statistics. An operational/ compliance audit (Institute of Internal Auditors, 2012) using HUD's 60% pass/fail threshold (GAO, 2009) provides further quantitative analysis of RQ4. The Critical Incident Analysis (CIA) frameworks of Radford (2006), Lister and Crisp (2007) and Halquist and Musanti (2010) address the challenge of examining and interpreting the unstructured qualitative data collected for RQ4 that is inherent in participant observation (Lambert, Glacken, & McCarron, 2011). However, only one of Halquist's four probing questions is considered: What power relationships between the staff and clients are being expressed?

RESULTS

Table 2: ***Client Length of Stay and Disposition***

Client Code	Age	Entry Date	Exit Date	Total Days	Disposition at End of Study
P1	23	4/16/10	12/10/10	235	Residential Treatment Home
P2	34	6/16/10	11/12/10	147	Permanent Housing (HUD-VASH voucher)
P3	41	7/1/10	Unknown	314	Still in shelter
P4	42	8/1/10	1/5/11	155	Disciplinary dismissal to Residential Treatment Home
P5	38	8/1/10	unknown	284	Still in shelter
P6*	36	10/29/10	12/8/10	40	Provider B's SRO unit (found by client)
P7	54	11/1/10	unknown	194	Still in shelter
P8	29	11/11/10	12/9/2010	29	HPRP Apartment placement
P9	22	11/16/10	unknown	179	Still in shelter

Note. Study period was October 29, 2010 to May 14, 2011. Client P6 is the PI.

As indicated in Table 2, 44% of the clients were still in Provider A's Operation First Step program at the end of the study. Twenty-two percent (22%) were placed in a residential treatment home and 22% exited to apartments. One client found transitional housing in Provider B's SRO unit on her own.

The mean length of stay was 175 days (n=9, Mdn=179, SD=97). Three extreme values of 29, 40, and 314 days did not pass the outlier test (z = - 1.50, - 1.39, and 1.43, respectively) but served as critical cases for inferential and qualitative analysis. The mean length of stay rose to 214 days (n=7, Mdn=194,

SD=64) with the two extremely low values removed and settled at 198 days (n=6, Mdn=186, SD=52) when all three extreme values were omitted—a marked 39 and 23 days longer than the overall mean.

Research Question 1 (RQ1): Typical length of shelter stay

A single sample t-test determined that the women's observed mean stay of 175 days was significantly longer than the expected 30-day limit ($\mu_1 > \mu_0$, t = 4.47, p = 0.001).

Research Question 2 (RQ2)*:* Individual factors influencing length of stay

Two zero-order correlations–the first with all clients included (r = 0.18, $r^2 = 0.03$, p = 0.33) while the second removed the three extreme data points of 29, 40, and 314 days (r = –0.09, $r^2 = 0.007$, p = 0.44)—showed no direct relationship between age and length of stay. Age accounted for only 3% and less than 1% of the variation in length of stay, respectively, and was not statistically significant.

No significant difference was found between minority clients (e.g. Hispanic, Black/African, and Native American combined) and White clients by a two sample t-test (t = -0.95, p = 0.19). Race accounted for a modest 12% of the variation in length of stay as shown by a point biserial correlation ($r_{pb} = –0.34$, $r^2 = 0.12$, p = 0.19). Likewise, a one-way ANOVA [F(2,6)=0.03, p=0.05] and three point biserial correlations found no significant difference by marital status.

Conversely, a zero-order correlation showed a very strong, significant, inverse relationship between length of stay and education (r = –0.98, $r^2 = 0.97$, p = 0.008), where education level explained nearly 97% of the variation. Further, a point biserial correlation confirmed a very strong, significant, inverse relationship between length of stay and self-advocacy ($r_{pb} = –0.82$, r^2=0.67, p = 0.003) emphasized by Clients P6 and P8. In fact, self-advocacy accounted for 67% of the variation in length of stay.

Education and Self-Advocacy

A point biserial correlation determined that women with more education tended to advocate for themselves significantly more than women with less education ($r_{pb} = –0.77$, $r^2 = 0.59$, p = 0.007). However, first order partial correlations revealed that self-advocacy (k) had no effect on the relationship between education (i) and length of stay (j), $r_{ij.k} = –0.97$, $r^2 = 0.93$, t = –9.08, p = 0.0001 (two-tailed). Even when controlling for the effect of self-advocacy, education explains 93% of the variation in length of stay. Further, first order partial correlations showed that education (i) had an insignificant, anteceding control effect on the direct path from self-advocacy (k) to length of stay or shelter exit (j), $r_{kj.i} = –0.55$, $r^2 = 0.30$, t = –1.61, p = 0.16 (two-tailed). Although statistically insignificant, this finding may be of practical importance. Thus, when controlling for the effect of education, self-advocating behaviors alone may explain only 30% of the variation in length of stay compared to 67% with education included.

Research Question 3 (RQ3): Environmental factors influencing length of stay

A single sample t-test for all unemployed women (μ_{13}= 175 days) showed significantly longer shelter stays than the expected 30-day program limit ($\mu_{13} > \mu_0$, t = 5.78, p = 0.0003). However, a two

sample t-test uncovered only a marginally significant difference between the observed mean of 175 days and 87.5 days ($t = -1.53$, $p = 0.08$) for unemployed and employed women, respectively. Moreover, a point biserial correlation uncovered a weak inverse relationship of marginal significance ($r_{pb} = –0.48$, $r^2 = 0.23$, $p = 0.08$) between employment status and length of stay, where 23% of the variation in length of stay was accounted for by employment.

Research Question 4 (RQ4): Organizational factors influencing length of stay

An operational/compliance audit assessed the staff's performance on the 87 non-negotiable standards established in the Operation First Step program guidelines. Provider A received an overall "Substandard" rating for being only 46% compliant. In fact, staff followed established policies and procedures in only 9 of the 27 areas evaluated—a mere 33% success rate by subsection. This substandard performance, primarily in case plan development, had a quantifiable impact on length of stay.

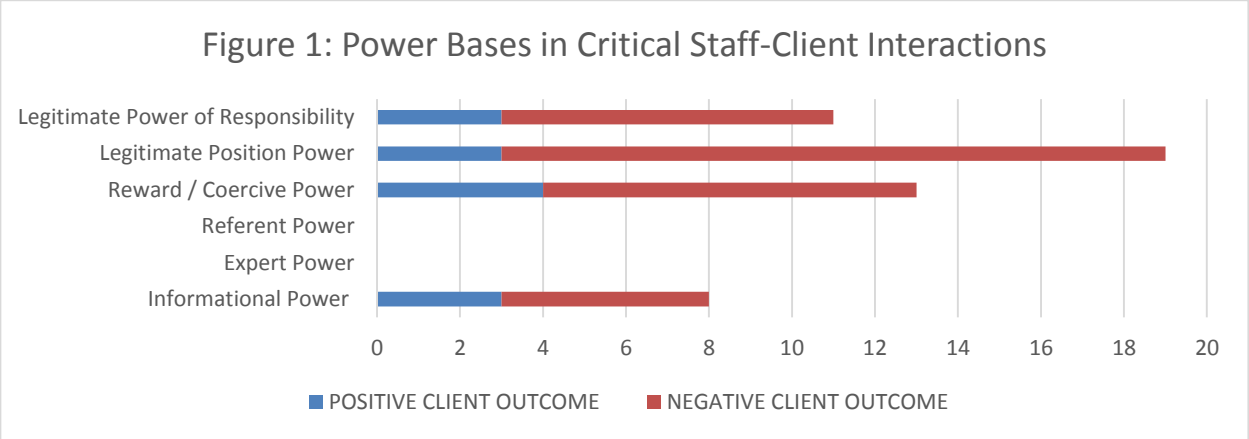
For example, Client P7 spent 120 days of her 194-day stay waiting for her case advocate to print an authorization form that only her case advocate could provide in order to get a government-issued identification (I.D.) card. With the I.D., Client P7 would have been able to apply for Supplementary Security Income (SSI) and have the proof of income needed to request a parole transfer to her home state where she could live with relatives. The client lamented, "She just went into the computer and printed it out. Just like that. I don't understand why she wouldn't do that in the first place."

Moreover, Client P3's 10-month shelter stay could have been reduced by at least 146 days or almost five months. This client began part-time employment 168 days after shelter entry, which qualified her to exit the shelter via HUD's (n.d.) Homelessness Prevention and Rapid Re-Housing Program (HPRP). However, Provider A's HPRP Housing Locator frequently missed appointments with the client and a potential landlord—particularly when the client self-selected the apartment. Client P3 reported that the Housing Locator simply "won't respond to me when I find an apartment that's in a neighborhood better than the ones she wants to put me in."

Finally, 197 days of Client P5's nine-month shelter stay could also be attributed to the standards violations. Client P5 reported her case worker as being "absent for meetings 90% of time" and being unaware that she did not use her bed. The PI directly observed the client's extended overnight absences from the dorm five to seven days per week. From the PI's entry into the field until study end 197 days later, Client P5 reported making no plans with her case advocate or attempts to move.

The CIA analysis classified 34 staff-client interactions documented in the PI's online reflex journal (International Freedom Coalition, 2010b) and the operational audit as critical incidents. Eight (8) were themed as self-advocacy and removed from the CIA analysis. Of the remaining 26 incidents, 31% resulted in an immediate positive outcome for the homeless clients while 69% led to negative outcomes.

Figure 1 illustrates the staff's use of power. Staff employed 51 instances of the power bases during the 26 critical incidents, where multiple bases of power may have been used in any one incident. Of the 51 instances, 25% led to immediate positive client outcomes while 75% led to negative outcomes.



In the critical interactions resulting in a positive outcome, staff employed reward power (8%), informational power (6%), legitimate position power (6%), and legitimate power of responsibility (6%). Examples include: admitting the PI into the shelter (legitimate power of responsibility) and promising to recommend the PI as an HPRP candidate (legitimate position power, reward power).

The negative interactions exposed the staff's use of legitimate position power (31%), coercive power (18%), legitimate power of responsibility–neglect (16%), and informational power–withholding (10%). For instance, eight critical incidents (16%) involved client abuse, harassment, and intimidation (coercive power) by shelter staff and security personnel that meets the state's legal definition (Rhode Island General Assembly, n.d.a, n.d.b, n.d.d). The substandard management and administrative neglect of Clients P7, P3, and P5's cases as highlighted by the audit and the refusal to grant the PI access to vocational and HPRP resources illustrates the negative use of legitimate position power, informational power, and legitimate power of responsibility.

CONCLUSION

Education, self-advocacy, administrative neglect, power, and to a lesser extent employment, rise as the most important factors leading to shelter exit. By definition, self-advocacy hinges upon knowledge. Knowledge and education as informational power lead to independence. However, shelter staff consistently withheld informational power from clients, which directly increased length of stay. Instead, staff primarily employed coercive power which requires client dependence and hinders self-sufficiency (DeWard and Moe, 2010) or legitimate position power which possibly created a perceived imbalance of power, reduced or eliminated client engagement, and possibly led to a failure for clients to advocate for themselves (Jonikas, et al., 2011). The lack of self-advocacy increases shelter length of stay.

RECOMMENDATIONS

Further study is needed to empirically measure the power used in staff-client interactions; the resulting change in homeless clients' attitude, action-taking, and self-advocacy behaviors; and the impact on length of stay and operating costs. Answering all of Halquist's probing questions may inform shelter policy to improve staff-client interactions, produce more positive outcomes, and reduce operating costs.