Chapter 1.2

Shelters for the Homeless: Learning from Research

ROCH HURTUBISE, PIERRE-OLIVIER BABIN, AND CAROLYNE GRIMARD

In spring 2006, in a regional round table discussion on homelessness in Quebec, we noticed that many practitioners were worried about the role of shelters and of their importance in addressing the problem. What is the mission of these shelters? Are they the solution or do they merely reproduce conditions one would find in an asylum? Can they offer a way out from the street? The questions are numerous. What can we learn from the research in social and human sciences?

What is a shelter? Definitions of homelessness are numerous and subject to different interpretations (Gaetz, 2004; Roy & Hurtubise, 2007, 2004). The definition of a shelter is no less problematic. In its initial sense, a shelter is a place where one goes to avoid danger or a place where people who have no place else to go can gather. A brief survey of the terms in use sheds light on the diversity: shelter, hostel, emergency shelter. In French: *refuge*, *maison d'hébergement*, *auberge*, *hébergement d'urgence*.

The shelter can be defined by the number of beds (from a few to several hundred) or by the nature of the services offered. In most cases, the services offered by the organisms are not limited to temporary hous-

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ing and food. Moreover, some organizations offer emergency housing services while refusing to be associated with shelters. For example, in many cities, one may find shelters that serve both abused women and homeless families, while in Quebec the network of shelters for women who are victims of domestic violence are largely independent of those for homeless people. It would probably be more appropriate to use the term *emergency housing measures* (Hopper, 2004). However, the larger shelters remain the best-known representatives of the services available to homeless people, as they are frequently mentioned in the media, particularly in crisis situations, when they are often overcrowded.

Who uses shelters? There seems to be a consensus on the necessity of distinguishing the population of these shelters and the population of people without a home. Not all homeless people are shelter users, and reducing the former to the latter often renders part of the homeless population invisible.

This review is in four sections: (1) a history of shelters; (2) a portrait of shelter users; (3) intervention practices associated with the primary mission of shelters; (4) criticisms of shelters.

A history of shelters

Traditionally associated with resources offered to beggars by religious communities, shelters have evolved over the years. The first shelters were created in cities where an influx of individuals seeking work increased the number of people without housing. This temporary housing developed in parallel to other solutions like shantytowns or camps. Initially established as temporary services for the homeless population, they eventually became permanent (Dordick, 1996).

The development of shelters at the end of the 19th century is related to developments in the economy (industrialization and urbanization) and the ethic of work as a way to distinguish the honest working man from the idler. Two waves of modernization of shelters occurred in the first half of the 20th century. The first improved the hygienic and sanitary conditions of the area by equipping the facilities with basic sanitary equipment; the second redefined the mission of the shelters by services to help shelter users reintegrate into society (Aranguiz, 2005; Aranguiz & Fecteau, 2000). In the postwar period, shelters were reaffirmed in their

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more traditional role of emergency housing, with the responsibilities of re-adaptation relegated to the realm of public services.

Deinstitutionalization policies designed to maintain people with physical or mental health problems in the community changed the population using shelters and community services. For example, from 1984 to 1988, the number of people using shelters in New York increased from 5,000 to 8,000. Most suffered from addiction or mental health problems.

Visions of the role of shelters differ: is it emergency housing intended to be used only in the short term, or support and protection offered in the long term (Gounis & Susser, 1990)? Towards the end of the 1980s, the creation by the city of Montreal of a referral centre for homeless people caused many problems: first, the challenge of setting up the centre; second, ensuring the safety of the users; third, opposition from the residents of the neighbourhood (Charest & Lamarre, 2000). Today, when new shelters are built or when old ones relocate, they often face opposition from local residents, merchants, property owners, and NIMBYists ("not in my backyard"). In these debates, the people who have the strongest voice, who are able to block these projects, are generally owners of large private properties (Ranasinghe & Valverde, 2006).

In the 1990s, critics of shelters became more harsh. Shelters were perceived as part of a system that tries to hide the homeless population. Because the presence of homeless people in public areas is seen as an annoyance and a menace, two strategies for fixing this problem emerged: designing these spaces so that they are less attractive to homeless people (architecture, streetscape) and controlling the behaviour of homeless people through litigation. This effort to rid cities of people deemed as "undesirable" encouraged the development of shelters as a way of shielding the population from homeless people (Johnsen et al., 2005).

A Portrait of Shelter Users

The Numbers

It is important to distinguish the homeless population from the people using shelters. Too often, the number of nights in shelters is used as an indicator of the homeless population. Thus in certain cities, the absence of shelters would lead to an underestimation of the homeless population.

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Following a first generation of studies based on the opinions of experts and witnesses, a second based on interviews with shelter users has emerged. A more complex array of investigative procedures has yielded more precise approximations (Firdion & Marpsat, 1998). Attempts are under way to standardize procedures and facilitate comparisons among cities – for example, the creation of an information system on people and families without a home (HIFIS). In 2001, Statistics Canada estimated the number of people in shelters at 14,150 on census day, but this number must be interpreted with caution.

Although the numbers vary, statistical studies help identify the converging trends of the users' characteristics. Three trends are clear: the increase in the homeless population, the diverse characteristics of homeless people, and the aggravation of problems linked to the situation. If certain censuses show stability in the number of users from 1990 to 2000 (United States Census Bureau, 2001), others show a considerable increase (Goldberg, 2005). The homeless population which uses shelters does not constitute a homogenous group (Hecht & Coyle, 2001; Novac et al., 2002). Generally, youths are less inclined to use public services and shelters for homeless people, and prefer life on the streets (Brooks et al., 2004; De Rosa et al., 1999).

Use of shelters varies among different groups. In Canada, immigrants and Aboriginal people are under-represented in shelters (Distasio et al., 2005; Fiedler et al., 2006), whereas in the United States, Blacks and Hispanics are over-represented (Gondolf et al., 1988). The number of men using shelters who are involved in the judicial system is four times greater than in the general population (Tolomiczenko & Goering, 2001).

People in shelters may express more satisfaction about their environment than those on the street and do not associate the shelters with a loss of freedom (La Gory et al., 1990). However, youths may see shelters as too restrictive, and often distrust the staff and associated social workers. The community network takes over for other services (Levac & Labelle, 2007; Poirier & Chanteau, 2007).

Profiles of users enable us to determine different types of homelessness: chronic, cyclical, or temporary (Acorn, 1993). Certain groups (the elderly, or those suffering from mental health problems, addictions, or physical problems) stay for prolonged and repetitive periods. A few

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situations seem to be particularly problematic: users who have exhausted their personal and family resources and who are also rejected by the public system often express aggressive behaviour towards aid workers and other users.

Racial origin seems to be strongly associated with the length of the stay in the shelters; Caucasian people stay less than half as long as Black people (Culhane & Kuhn, 1998). However, in winter, stays are usually longer because of harsher weather. Simard (2005) estimated the average stay in a large shelter to be 355 days. Most beds (60 percent) are used by individuals staying more than three months, and 30 percent are used by those who stay more than a year.

Users of shelters are not necessarily unemployed; some may have precarious or low-wage jobs. Research has established profiles of usage according to people's needs: transition towards stable housing, rest, emergency, usage in addition to day centre use (Grella, 1994).

In 2006, the "tent crisis" in Paris raised the question of homeless people refusing to use shelters. The initiative of a humanitarian group consisting in distributing tents during the winter season to improve the living conditions of homeless people provoked a social crisis. Homeless people spoke out publicly about life in shelters and explained that the life inside the tent presented a better alternative (de Fleurieu & Cambaud, 2006). Elsewhere, homeless people also refuse to use the housing resources available because they are deemed constraining and threatening (Hopper, 2003).

Epidemiological Profile

The health status of people using shelters presents a serious challenge (Carrière et al., 2003, Hurtubise et al, 2008). The use of shelters can even cause health problems through sleep deprivation, personal hygiene difficulties, or limited space for storing personal goods (Power et al., 1999). Users are often hesitant to use normal health services, treatment and prevention practices, and suffer health problems as a result (Frankish et al., 2005; Harris, 1994). The mortality rate varies from two times to eight times higher than that of the general population (Barrow et al., 1999; Hwang, 2000).

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Despite a decrease in schizophrenia cases (Geddes et al., 1994), some studies suggest that between 40 and 60 percent of the homeless population suffer some form of mental health problem, such as anxiety, depression, or suicidal tendencies (Fournier & Mercier, 1996; Poirier et al., 2000). Drug and alcohol problems are common. Shelters may contribute to the spread of infectious diseases such as tuberculosis or parasites such as lice (Marks et al., 2000). The question of health calls for a better understanding of the strategies used by people who are homeless (Wadd et al., 2006).

Homeless people have difficulty accessing resources to take care of themselves (Boydell et al., 2000; Laberge, 2000). Often, they also end up adding to their health problem by waiting too long before seeking help (Desai & Rosenheck, 2005). They often use the emergency services of hospitals (Kushel et al., 2001; Marks et al., 2000; Stein et al., 2000; Thibaudeau, 2000). Despite their obvious needs, homeless people are poorly served when it comes to health services, either prevention or intervention (Roy et al., 2006; Webb, 1998).

Users and Appropriations

Firdion and Marpsat (1998) point out that the differences between short- and long-term shelter users are not clearly defined. A more dynamic approach that focuses on users' characteristics is helpful. Four groups can be distinguished: (1) those who make maximum use of resources during medium- and long-term re-integration into society; (2) those who find their own solutions to problems, without the use of resources for the homeless; (3) those who make ad hoc use of emergency shelter resources; (4) those in precarious housing situations (cars, trailers, squatting). A person who has used up all his or her personal, family, and community resources, may turn to a shelter as a last resort (Poole & Zugazaga, 2003). A focus on understanding the different solutions used by the homeless to compensate for a lack of housing allows us to better study the survival methods of those involved (Elias & Inui, 1993). According to Hopper (2003), understanding the history of the people in homeless situations enables us to propose more complete intervention models.

Life in shelters is far from ideal, and living conditions are often described as similar to those in traditional asylums (Simard, 2000). The atti-

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tudes of workers and the organizational structure of shelters may create a context favourable to violent behaviour among users (Liebow, 1993).

Dordick (1996) proposes a description of the "social world" in shelters. For example, sexual practices, seldom mentioned in scientific literature, are an important preoccupation, even in areas that offer little or no privacy. Couples may form in shelters. Rituals of engagement have been observed among these couples, which imply support and comfort in shelters as well as outside them.

Beyond Emergency Sheltering, Intervention Practices

Research on programs for homeless people that involve shelters can be divided up into four categories: (1) functions and approaches; (2) sheltering and housing as a stepping-stone to social re-integration; (3) shelters as a place for intervention; and (4) program evaluations.

Functions and Approaches

Studies of how shelters are organized use two perspectives: (1) the desired approach of professional workers and volunteers, and (2) the rules and guidelines that regulate life in shelters.

Shelter staff may develop an understanding of the life conditions of the homeless and of the state of mind and characteristics displayed by shelter users. Flexibility, understanding, the ability to listen and to adapt to a person's needs are all qualities that are valued in practitioners who have to constantly adapt to very diversified needs.

Most shelters set rules and regulations that outline acceptable and unacceptable behaviour for both shelter users and practitioners (Neale et al., 1997; Roy et al., 2000). For example, permission to enter the shelter may depend on the person's mental state (intoxication, aggressiveness, under the influence of drugs), personal characteristics (gender, age, cultural background), or history with the shelter (limited number of visits). Once inside the shelter, there are rules governing personal hygiene (showering, changing clothes), curfew and wake-up times, respecting others (noise, aggressive behaviour, violence), and participation in group chores (food preparation, dishwashing, chores). Repeated failure to re-

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spect the rules will result in a penalty such as temporary or permanent exclusion, extra chores, or reduced access to services.

Studies of intervention practices sometimes take the form of typologies of shelter operations (Mosher-Ashley & Henrikson, 1997; Pelège, 2004). Shelters gather information from users and can target problems to refer residents to appropriate resources or services. Some shelters promote job readiness through in-house training centres, social enterprises, or by employment groups. Others focus on health needs and orient users towards services that correspond best to their needs. The challenge of accessibility is a central point; there are numerous examples of cases where needs were clearly defined, but accessibility was limited by cultural, organizational, or administrative barriers (Roy et al., 2006). Services are not available in all shelters and the complex problems of the homeless are not always taken into consideration in those offered (Berg & Hopwood, 1991). For example, many of the homeless suffering from mental health problems use shelters as a substitute to permanent and more appropriate housing (Hopper et al., 1997).

Sheltering and Housing as a Stepping Stone for Social Insertion

Housing is a right, a social norm, a behaviour stabilizer, and a status symbol (Dorvil & Morin, 2001; Fuller-Thomson et al., 2000; Laberge & Roy, 2001). A home is a social anchor point for individuals. This means distinguishing between *shelter* and *housing*: the first implies a temporary way of life that offers help that may include some form of rehabilitation, the second is a stable way of life that in no way implies any social or therapeutic needs (Dorvil et al., 2002). Numerous projects in shelters have tried to facilitate housing for the homeless.

A stay in a shelter constitutes an ideal occasion to work on a person's ability to manage their own home. Shelters allow users a temporary experience in a stable and safe environment (Peled et al., 2005). From this point of view, the role of shelters is to favour the transition towards stable housing, a move that implies not only finding a place to live but also building a solid foundation and a social network in the community (Friedman, 1994). Follow-up after leaving the shelter is an essential condition to the success of reintegration, and is a lengthy process. By all accounts, residential stability is very fragile during the first

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year and only in the second year do most people settle down (Dunlap & Fogel, 1998).

During the 1990s, advocates for the homeless focused on the right to housing as an alternative to solutions that relied essentially on a quick response to a crisis and poverty situation. The right to *housing* took precedence over the simple right to *shelter* in the platforms of many human rights groups (Bresson, 1997; Hopper, 1998). Subsequently, the Council of Europe in its final declaration to the Congress of Local and Regional Authorities (1994, p. 183) noted: "The right of all human beings to decent, affordable housing of a certain standing, adapted to essential needs is a fundamental right recognized by, among others, the Universal Declaration of Human Rights and where implementation is an obligation for all of society without exception or discrimination" (translated from the French).

Research on housing rights includes comparative analyses of the costs of the services used by the homeless (shelters, public services) and the costs associated with long-term stability in a dwelling. For example, investments in subsidized housing for the homeless would decrease the costs of other services for the homeless. The savings generated would largely cover the financing of subsidized housing. Moreover, improvements in the quality of life of homeless people suffering from mental health problems can translate into a reduction in shelter use, hospital visits, and the number of people incarcerated (Culhane et al., 2002). The impacts of this type of initiative are numerous: better quality of life, increased self-esteem, development of self-affirmation skills and rights advocacy, developing a network, rights of citizens and social participation (Metraux et al., 2003; Novac & Brown, 2004; Roy et al., 2003).

Shelters as Places for Intervention

Even if it is difficult to determine just how efficient they are, it is obvious that the interventions taking place in shelters often succeed in reaching out to a population considered marginal and fearful of public services (Levinson, 2004). Research tends to focus on the resources and the intervention models that target specific sub-groups: women, youths, the elderly, and individuals with mental health problems. There is less research focused on the interventions with adult males.

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Mental health tops the list of problems. Shelters offer basic support, but it is difficult to do so for those suffering from mental health problems. Grella (1994) suggests that shelters should offer options related to helping the homeless population suffering from mental health problems. A follow-up after the initial intervention (Hall, 1991) and long-term services are useful when dealing with homeless people suffering from mental health problems. Applebaum (1992), Dattalo (1991), and Hall (1991) suggest removing barriers to services, coordinating services, emphasizing patient participation, modifying rules on the protection of information, lobbying for social and psychiatric services, raising shelter workers's awareness of mental issues, and improving training.

More mental health services are offered inside shelters than physical health services (Mosher-Ashley & Henrikson, 1997). This fact raises questions about the responsibilities of community organizations relative to public services. Some experts fear the development of a parallel health system for homeless people. The intervention practices developed in shelters must be analysed within the context of the transformation of health and social services (Racine, 1993).

What are the best places and the most strategic moments to intervene and avoid a relapse? The post-shelter period is considered particularly crucial and follow-up to ensure the continuity of the process of emerging from homelessness is essential. Interventions through a network of community services can prevent the reoccurrence of homelessness (Susser et al., 1997).

Numerous programs have focused on reducing homelessness through a more intensive approach. Min, Wong, and Rothbard (2004) looked at the Access to Community Care and Effective Services and Support (ACCESS) program in the United States from 1993 to 1998. The program adopted a treatment model in the community combined with individual management of each person's case. The objective of the program was to help homeless people suffering from mental health problems emerge from poverty. The results suggest that managing each person's case individually can reduce the risk of chronic homelessness in people suffering from mental health problems.

Health practices usually consist of guiding the person towards available resources. Some nurses have developed a practice that involves

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regular visits to shelters and follow-up with shelter users. Strategies focus on the resolution of problems, empowerment, work with network personnel, and sharing resources (Denoncourt & Bouchard, 2006; Di Marco, 2000; Thibeaudeau, 2000). Some studies have evaluated the effectiveness of health services for homeless people. For example, a shelter-based convalescence facility can help workers supply health service needs better adapted to individual conditions, ensure a more complete treatment of medical and mental health problems, favour continuity of treatment, reduce drug dependency, and help individuals with social reintegration (Podymow et al., 2006).

Many interventions target sub-populations, particularly women, youth, and the elderly. Work with homeless women may call for a new approach inspired by the feminist movement that focuses on offering safe living conditions, valuing the autonomy of women, and establishing a trusting relationship (Goldberg, 1999; Gondolf, 1998; Sévigny & Racine, 2002). Most youth crisis centres follow similar goals: respond to basic needs (food, clothing, showers, a place to sleep, entertainment) and work to end marginality by helping youths develop everyday skills, find a place to live, manage a budget, use available resources, find employment, and, in certain cases, reconcile with their families. Approaches that combine education and behaviour change through a coping and stress management strategy facilitate the resolution of the crisis (Dalton & Pakenham, 2002; Teare & Peterson, 1994).

A few studies about services for elderly homeless people indicate a significant increase in this population. Physical health problems are significant and the barriers to services are numerous (Abdul-Hamid, 1997). In these cases, homelessness is often associated with a loss of autonomy and a decrease in support network; turning to a shelter may increase the effect of these losses in elderly people whose cognitive abilities are declining (Elias & Inui, 1993).

Researchers have also documented original initiatives − the addition of judicial services in shelters (Binder, 2001), the introduction of occupational therapy programs (Herzberg & Finlayson, 2001) or the use of ethnographic approaches in clinical work (Grisgby, 1992). These studies tend to be descriptive and do not identify the most effective practices.

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Program Evaluations

The literature includes evaluations of the impact and the efficiency of the services as well as the role of shelters in the fight against homelessness.

Numerous studies examine the contribution of a stay in a shelter to allowing individuals to escape homelessness and find permanent housing. There are many contradictory views. Short-term improvements may be followed by deterioration (the change is often temporary); in other situations, the transformations seem more permanent, especially when there is effective follow-up (Glisson et al., 2001; Peled et al., 2005; Pollio et al., 2006).

In certain situations, specific services in shelters are evaluated, for example, a decrease in behavioural problems in children of women participating in a conflict management program in centres for abused women (McDonald et al., 2006).

The role of shelters in ending homelessness can be looked at in two ways: (1) shelters as partners in intersectorial alliances networks in the fight against homelessness; (2) shelters as part of the continuum of care. Shelter administrators use diverse strategies to maintain services, such as tightening accessibility rules, or bridging with other resources (Goodfellow, 1999). With such a diverse clientele expressing complex problems, collaborations with external resources and the diversification of practices becomes a necessity.

Developing partnerships involves relationship building, clarifying expectations, identifying needs, sharing expertise, and evaluating the collaboration (Snyder & Weyer, 2002). Shelters can be the first step into a system of services, a place from which it is possible to evaluate a person's needs and begin implementing interventions. Coordination by a case manager can ensure follow-up and the continuation of the interventions (Feins & Fosburg, 1999). Effectiveness depends largely on the integration of many resources around the needs of the individual: prevention, outreach, emergency shelter, transitional housing, supportive housing, and affordable housing (Burt, 2004; Carter, 2005). The continuity of services seems promising in homelessness, but this approach presents ethical challenges that should be scrutinized in future research.

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Critical Analysis of Shelters

A body of research questions the role and the place of shelters as solutions to homelessness. These studies look at the homeless problem from a different angle and reveal some less than positive aspects.

A Total Institution?

Some authors favour Goffman's approach for analyzing homelessness (Pichon, 2002). From this point of view, shelters are viewed as total institutions, consuming all the time of their users and depriving them of freedom. The rules established to control the physical and social environment of shelters shape the users and reinforce their marginal identity. The culture of total institutions tends to alienate and depersonalize users, whose lives are defined by their belonging to the shelter. For users, this translates into a loss of autonomy and the feeling of domination and enclosure. This perspective allows us to understand conflicting roles and allegiances that are often viewed as irreconcilable (Stark, 1994).

The rules of some shelters show how encompassing shelter life can become. Underground practices may add a "black market economy" of sorts, such as food re-selling networks, protective services, control of privileges, and odd jobs. Three other factors affect life in shelters: (1) a majority of time is spent on organizing "living" in shelters, which leaves little time for other things; (2) personal networks and friendships may be fragile and short-term; (3) obligations towards other people must be respected, and leaving the shelter may be seen as abandoning these obligations (Dordick, 1996).

For Marcus (2003), this analysis neglects the role of collectivity in the lives of homeless people. The idea that shelters isolate users obscures the fact that for homeless people, shelters are one resource among many, and their strategy for survival and escape from homelessness draws on public, community, family, and personal resources. Shelter users are not completely defined by a sub-culture; they share values, beliefs, and norms with the general population.

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Shelterization: Confinement in a Marginal Area

Marginal affinity, the proximity between shelter users and professionals, denotes sharing of a common surrounding and the development of a sense of belonging to a marginal environment. This proximity is apparent in the participation of homeless people in daily chores, the fluidity of the roles of interveners, and the absence of standards. In fact, services intended to aid in recovering from homelessness actually favour the reproduction and maintaining of shelter life. Personal failures encountered by users during their efforts to find stable housing sometimes reinforce their sense of belonging to shelters, the place that accepts them for who they are and doesn't judge them (Gounis & Susser, 1990).

The idea of shelterization has been discussed by Novac, Brown, and Bourbonnais (1996) and Kozol (1988). A certain social pathology engulfs people in lethargic situations, so that they become incapable of taking responsibility for their lives, neglect personal hygiene, and lose interest in escaping their situation. For users, this situation is defined by a loss of autonomy, a lack of self-respect, and a loss of responsibilities. Confining rules, the difficulty of being able to care for oneself, and personal problems can create a larger dependency on the services and an enclosure in homelessness (Elias & Inui, 1993).

Shelterization also emphasizes the social processes of enclosure in homelessness, similar to the concentration of poor populations in ghettos. The abuse of shelters is not just a personal problem. Users become psychologically and economically tied to social assistance programs, and adapt by developing survival mechanisms that keep them homeless. Shelterization creates a sub-culture based on a common language and the assimilation of shared ideas and values. Furthermore, tolerating delinquent behaviours may lead to a redefinition of what is normal behaviour. Regardless of the dangers and the depersonalization, users are reluctant to leave the shelters (Grunberg & Eagle, 1990).

Social Regulations and the Role of Policies

Shelters are not neutral sites, they represent the borders of marginality where street rules apply (Zeneidi-Henry, 2002). Many authors question the role of the state in perpetuating homelessness. The reduction of ser-

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vices has resulted in a housing crisis that forces certain people to use emergency shelters (Layton, 2000). At the same time, the medicalization of problems or assertions that certain situations represent individual failures mask the real causes of people's difficulties (Damon, 2002; Marcus, 2003).

Studies focus on two areas: housing policies and urban planning and security policies. Some authors believe that policies focusing on access to housing should be reinforced and could help solve homelessness (Roman & Berg, 2006). Here we see the debate between targeting the clientele as a necessary condition for the implementation of efficient solutions, and the adaptation of existing general services by favouring accessibility and support for people (Dattalo, 1991; Fontaine, 2000).

The shelter plays an intermediary role between homeless people and the community; it becomes, for some, a type of affordable housing. The shelter system can be seen as an official willingness to neutralize a problem. In fact, the location of a shelter, its structure and operational modalities influence the type of reintegration that homeless people can expect in a community. Offering many services within a shelter contributes to people's isolation, because there is no incentive for them to use outside services or to familiarize themselves with the location of resources and services (Hartnett & Harding, 2005).

There are two types of shelter. Some offer little comfort and few financial resources, and refer users to other services. Others offer more comfort and better resources, providing a personal approach to people who have the potential to make the transition to permanent housing. The emergency shelter network is therefore hierarchal. The sheltered population is not an arbitrarily formed group; it is the result of a selection process. Homeless people who can convince officials that they have the potential to benefit from services often gain access to better quality centres (Soulie, 1997). The hierarchy represents a social control process that, through prioritization and targeting certain clientele, allows service providers to distinguish "good" homeless people from "bad" homeless people; the "good" group may qualify for intensive interventions, because their problems are often less intractable (Hurtubise, 2000).

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Research Challenges

Shelters vary widely. Their history and their development reveal the various ways that individuals have protested to fight against homelessness. For human and social science research, shelters are important partners. Shelter workers are key sources of information for the evolution of the face of homelessness and help researchers reflect on and analyse their approach.

Some research suggests that shelters are the best way to handle the homeless problem. However, most studies indicate that any solution to homelessness must include many participants and involve numerous sectors: community organizations, city governments, health and social services institutions, law enforcement agencies, and private and community practitioners. Research should continue to describe the various experiences of shelters and document their transformation. Studies are also needed to analyse programs and practices and identify the most effective interventions. Furthermore, critical analysis must continue to question ideas that are taken for granted. Since the homeless problem is so complex, solutions must be adapted to the diversity of the contexts to which they are applied.

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