

Shelter Health:

Essentials of Care for People
Living in Shelter

Ken Kraybill, MSW
Jeff Olivet, MA

The National Health Care for the Homeless Council

The National Health Care for the Homeless Council began as an element of the 19-project HCH demonstration program of the Robert Wood Johnson Foundation and the Pew Memorial Trust. We are now over 75 Organizational Members and over 700 individuals who provide care for homeless people throughout the country. Our Organizational members include grantees and subcontractors in the federal Health Care for the Homeless funding stream, members of the Respite Care Providers' Network, and others. Homeless and formerly homeless people who formally advise local HCH projects comprise the National Consumer Advisory Board and participate in the governance of the National Council.

Statement of Principles

We recognize and believe that:

- homelessness is unacceptable
- every person has the right to adequate food, housing, clothing and health care
- all people have the right to participate in the decisions affecting their lives
- contemporary homelessness is the product of conscious social and economic policy decisions that have retreated from a commitment to insuring basic life necessities for all people
- the struggle to end homelessness and alleviate its consequences takes many forms including efforts to insure adequate housing, health care, and access to meaningful work.

Mission Statement

The mission of the National Council is to help bring about reform of the health care system to best serve the needs of people who are homeless, to work in alliance with others whose broader purpose is to eliminate homelessness, and to provide support to Council members.

Consistent with our Mission Statement, we:

- Advocate for universal health care and for the improvement of current systems intended to serve people who are poor and homeless
- Research critical issues
- Train and organize health care providers, service agencies, and homeless people themselves to improve care
- Publish newsletters, monographs, action alerts, policy statements, training videos and books
- Collaborate with a broad range of public and private entities interested in the problems of health care and homelessness.

Acknowledgments

This project was developed with the support of the Health Resources and Services Administration. The views expressed in this document do not necessarily reflect the views of HRSA.

The development of the project was guided by the Shelter Health Advisory Committee, consisting of Edward Bonin, Sharon Brammer, John Gilvar, Amy Grassetto, Linda Olivet, Alina Perez-Stable, Karen Rotondo, Marion Scott, and Allan Ainsworth.

Also indispensable to this project have been Heather Barr, Beth Miller Kraybill, Sharon Morrison, Hannah Bouldin Olivet, Pat Post, and Marcia Stone.

As always, John Lozier has provided great vision and support.

This guide draws extensively on Marsha McMurray-Avila's book *Organizing Health Care for Homeless People*, Ken Kraybill's *Outreach to People Experiencing Homelessness*, and *The Health Care of Homeless Persons: A Manual of Communicable Diseases and Common Problems in Shelters on the Streets*, Jim O'Connell, editor. *The Health Care of Homeless Persons* was published by the Boston Health Care for the Homeless Program and generously shared with the National Council for this and other purposes. Homeless Health Care Los Angeles and the Seattle-King County Health Care for the Homeless Network have also done pioneering work in the area of training shelter providers, and we have utilized and adapted their materials for this Guide.

Additionally, we have drawn from the work of many other organizations for this Guide, and we have tried diligently to give proper attribution. We are deeply appreciative of all the work that has given us a foundation for this publication.

Drawing on the wisdom of many, we have attempted to create a document that will be useful to many. Please feel free to duplicate and adapt these materials for your own training and operational purposes; attribution as to source will be appreciated. Reproduction or sale of these materials for profit is prohibited.

Thanks to you all,

Ken Kraybill and Jeff Olivet
May 2006

Table of Contents

I.	Why This Guide? Why Now?	7
	The Tool Kits	8
	A Guide for Shelter Providers	9
	Ways to Use This Guide	10
	The Causes and Conditions of Homelessness	11
	Homelessness and Health Care: Fundamental Issues	13
	Understanding the Connections Between Poor Health And Homelessness	15
	Human Rights, Shelter, and Health Care	17
	Thinking of Hosting a Homeless Shelter	19
II.	What You Need to Know	25
	Bringing Health Care into the Shelter	27
	The Tool Kits	28
	The Facts on Common Health Conditions	29
	The Facts of Lice	45
	Intake, Showers, and Clean Sheets: Heading Off Infestations In Homeless Shelters	46
	The Top 4: Asthma, Diabetes, Cardiovascular Disease, and Seizures	47
	About Asthma	48
	About Diabetes	50
	About Cardiovascular Disease	53
	What To Do If Someone is Having a Seizure	56
	Health Promotion	57
	Health Promotion in Shelters	58
	Homeless Family Facility Nutrition Guidelines	59
	Why Dental Care Matters to Homeless People	62
	Environmental Health and Safety	65
	The Tool Kits	66
	Hand Washing	67
	Guidelines for Environmental Safety in Shelter	68
	Guidelines for the Control of Communicable Disease in Shelter	69
	Standard Precautions in Shelters	71
	Sample Shelter Policies	72
	Environmental Health is Not Just About Control of Disease	80
	Safety Manual	81

For the Women of Katrina and Other Disasters	86
Making Shelters Safe for Transgender Evacuees	88
A Word About Animals and Environmental Health	90
Mental Illness and Substance Use Disorders	95
The Tool Kits	96
Effective Approaches	97
What Works	98
Suggestions for Relating to a Person Experiencing Mental Illness	100
Suggestions for Relating to a Person Experiencing Intoxication	101
Understanding Addiction	102
Principles of Effective Drug Addiction Treatment	103
Suicide	105
Suicide Myths and Facts	106
Signs of Depression and Possible Suicide Risk	107
P.L.A.I.D. P.A.L.S.	108
Glossary of Common Mental Health Terms	109
Glossary of Selected Terms Related to Substance Use Disorders, Treatment, and Recovery	114
Taking Care: Coping with Grief and Loss	121
The Tool Kits	122
When the Hurricane Hits	123
Care for the Caregiver	125
Common Causes of Stress in Homeless Services	126
Signs and Symptoms of Secondary Traumatic Stress	127
Self-Assessment Tool: Self-Care	128
Finding Resiliency and Renewal in Our Work	130
Caring for Your Self, Your Soul, Your Sanity	132
Mindfulness and Self-Care for Shelter Providers	133
Helping Others Cope with Grief and Loss	135
Reactions to Loss	136
Keys to Understanding and Accepting the Grief Process	137
Some Suggestions to Help Grieving People	138
Recovering From the Aftermath of a Disaster	139
Communication and Connection	141
The Tool Kits	142
Common Human Needs: The Basis for Outreach	143
Seven Human Needs	144
Frameworks of Engagement	145
Purpose and Principles of Outreach	148
Where Outreach Happens	149

Shelter Health:
Essentials of Care for People Living in Shelter

Services Provided Through Outreach and Case Management	150
Good Communication	151
OARS: Open Questions	152
OARS: Affirmations	153
OARS: Reflective Listening	154
OARS: Summaries	155
Creating a Listening Environment	156
Sustaining Community Dialogue and Response	157
The Tool Kits	158
Working Effectively in the Community	159
Checklist for Making Successful Referrals	160
Everyone Hates Meetings	161
Meetings Stink	162
Ten Tips for Effective Meetings	164
Guiding Principles and Shelter Standards	165
Disaster Planning	172
When Disaster Strikes, Health Care for the Homeless Takes to the Streets	178
III. OK, Now What? Next Steps	179
Next Steps	181
Tips for Trainers	182
Lessons Learned	189
IV. More Resources	193
List of Organizations	195
List of Acronyms	197
Further Reading	198

Why This Guide? Why Now?

The Tool Kits

At the beginning of each section of this Guide, readers will find lists that outline the contents of the Tool Kits that can be found in electronic form on the CD that accompanies this Guide. While some of the tools and handouts are found both in the Guide and in the Tool Kits, most of the items listed below are only found in the Tool Kits. They are to be used to supplement the material in the Guide and to provide shelter providers with day-to-day tools for use in the shelters.

Tool Kit A: General Information

- A-1 “Why Are People Homeless?” A fact sheet from the National Coalition for the Homeless
- A-2 “Homeless Children: America’s New Outcasts” from the National Center on Family Homelessness
- A-3 “Internally Displaced Persons”
- A-4 “Right to Health”
- A-5 “Right to Housing”

A Guide for Shelter Providers

The National Health Care for the Homeless Council provides publications and trainings on providing effective health care for homeless persons. In late 2005 and early 2006, we have chosen to focus our efforts on shelters that have been created to house persons displaced by the recent hurricanes, and on pre-existing shelters that have absorbed other refugees from those storms.

Serious health problems are common among homeless persons, and shelter settings may pose or exacerbate particular health risks for residents and service providers, as well as opportunities for important health care interventions. This guide will familiarize shelter providers and others who provide services in shelters with topics such as:

- Recognizing common health risks and conditions of homeless persons
- Organizing health screenings and on-site clinics
- Making effective referrals to community health care providers
- Precautions to prevent the spread of infectious diseases
- Responding to substance abuse, mental health problems and PTSD
- Safety concerns for residents and providers
- Coping with grief and loss
- Nutrition and food handling

This guide has been designed for communities where providers of shelter and other services can come together, learn about and discuss the issues, and plan individual and collaborative solutions. The guide is not intended to be a step-by-step “how-to” manual for setting up shelter services, but rather aims to provide tools and support to help shelter providers respond more effectively to the health needs of residents.

This guide has been designed as part of a larger training effort, and is most effective when used in conjunction with a formal training of its contents. These trainings are available from the National Health Care for the Homeless Council.

The National Health Care for the Homeless Council is a twenty-year-old organization of local health agencies, individual clinicians, respite care providers and people who have experienced homelessness. To learn more about the National Council’s work, please visit www.nhchc.org.

Ways to Use This Guide

- To orient and train new shelter workers and volunteers
- To provide a resource for in-service/continuing education sessions within an agency
- To bring together shelter workers from various community organizations for ongoing training and networking
- To use the resources and handouts to create or contribute to a “health library” in the agency
- To provide a resource for local government, civic leaders, and advocacy groups to plan and develop services for homeless people
- To aid shelter boards, directors, and managers to develop additional programs and services in the shelter
- To develop shelter policies and procedures
- To serve as a reference for shelter residents and other homeless/formerly homeless people to advocate for needed programs and services
- To use selected hand-outs taped on refrigerators, doors, walls as reminders for workers and residents
- To “train trainers” in using the guide to teach others about health issues in shelters
- To use for writing grants and position papers

The Causes and Conditions of Homelessness

Serious personal health problems and flaws in health care systems are major contributors to contemporary homelessness. Some health problems – addictions, schizophrenia, major depression, physical disabilities – are distressingly obvious, particularly in persons living in public spaces, while others are less visible but equally insidious, undermining the capacity to maintain stable housing and function independently. In far too many cases, a fragmented health care system has not responded adequately to the multiple needs of homeless persons, who are indigent and typically uninsured.

The Extent of Homelessness

Number of Homeless Persons Annually: **3.5 million**

Number of Homeless Persons Nightly: **842,000**

Number of Americans Who Have Experienced Homelessness: **12 million**

Urban Institute. *What Will It Take to End Homelessness?* 2001.

With recent natural disasters in the U.S., particularly Hurricanes Katrina and Rita, the realities of homelessness on our national landscape are changing, with large numbers of poor people displaced by storms trying to make a new start in new communities, many of which are already having enough trouble providing basic services for their own residents.

In the coming months and years, we will see how these large-scale disasters alter the social fabric of many communities. In the meantime, it is sufficient to recognize that these newly homeless individuals and families share the same basic health needs as those who were without homes before the disasters.

Homelessness and Poor Health

In 1988, the Institute of Medicine of the National Academy of Sciences found that homelessness and poor health were strongly correlated in three ways:

- **Health Problems Cause Homelessness.** Half of all personal bankruptcies in the United States result from health problems, and it is a short downhill slide from bankruptcy to eviction to homelessness. Moreover, some health problems that are more prevalent among homeless people than in the general population – such as addictions, mental illnesses and HIV/AIDS – are known to undermine the family and social supports that provide a bulwark against homelessness for many vulnerable people.
- **Homelessness Causes Health Problems.** People without homes are mercilessly exposed to the elements, to violence, to communicable diseases and parasitic infestations. Circulatory, dermatological and musculoskeletal problems are common results of excessive walking, standing, and sleeping sitting up. Homelessness and malnutrition go hand-in-hand, increasing vulnerability to acute and chronic illnesses.

Stresses associated with homelessness also reduce resistance to disease, account for the emergence of some mental illnesses, and enhance the false promises of relief offered by alcohol and drugs. Homeless people experience illnesses at three to six times the rates experienced by housed people.

- **Homelessness Complicates Efforts to Treat Health Problems.** The health care delivery system is not well attuned to the realities of living without stable housing.

Health care facilities often are located far from where homeless people stay, public transportation systems are insufficient or nonexistent in many places, and most homeless people don't have cars. Clinic appointment systems are not easily negotiated by people without telephones, for whom other survival needs (finding food and shelter) may take priority. Standard treatment plans often require resources not available to homeless persons, such as places to obtain bed rest, refrigeration for medications, proper nutrition or clean bandages.

These three correlations, noted by the Institute of Medicine nearly two decades ago, still obtain today. The mainstream health care system often is not prepared to contend with multiple co-morbidities commonly seen in homeless people, and is unwelcoming toward those with behavioral health issues who may appear unclean or threatening, cannot pay for services, and typically lack health insurance. Consequently, many individuals who are homeless have had bad prior experiences with the health care delivery system and avoid mainstream providers.

John Lozier

The Definition of Homelessness

The term "homeless individual" means an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations and an individual who is a resident in transitional housing.

Public Service Health Act, Section 330(b)(5)(A)

A homeless person is an individual without permanent housing who may live on the streets; stay in a shelter, mission, single room occupancy facilities, abandoned building or vehicle; or in any other unstable or non-permanent situation. A recognition of the instability of an individual's living arrangements is critical to the definition of homelessness.

Bureau of Primary Health Care, HCH Principles of Practice, Program Assistance Letter 99-12

Homelessness & Health Care: Fundamental Issues

Unstable housing

- Increases risk for serious health problems
- Complicates treatment adherence and recovery

Limited access to nutritious food & water

- Irregular meals with little dietary choice
- Higher risk for dehydration

Higher rates of communicable disease

- Respiratory/sexually transmitted infections including HIV and tuberculosis
- Skin diseases and infestations

Serious & complex medical conditions

- Increased risk for acute/chronic diseases with multiple co-morbidities
- More acute, life-threatening conditions due to delayed care

Lack of health insurance/resources

- Limits access to specialty care and prescription drugs
- Over half of homeless people nationwide are uninsured

Lack of transportation

- Limits access to health care
- Presents obstacle to employment, especially in rural areas

Discontinuous/inaccessible health care

- Due to lack of health insurance, high mobility, and fragmented health services that are ill prepared to deal with complex psychosocial problems

Chronic stress

- Anxiety associated with homelessness, struggle to meet basic needs
- Has negative effects on health, development, and learning

Developmental discrepancies

- Developmental regression/neuropsychological dysfunction common regardless of age, gender, diagnosis, or medical/psychiatric history

Higher rates of abuse

- Over 80% homeless women victims of severe physical/sexual assault
- Homeless children 2–3 times more likely than others to be abused

Behavioral health problems

- Higher incidence of mental illness, substance use disorders
- Increase risk for disease; can interfere with treatment adherence

Physical/cognitive impairments

- Secondary to trauma, mental illness, chronic substance use, infection, stroke, tumor, poisoning, developmental disabilities

Barriers to disability assistance

- Insufficient documentation of impairments for SSI/SSI claims
- Restrict access to housing and health care, especially for mentally ill

Cultural/linguistic barriers

- Minorities over-represented; health disparities apparent
- Limited English proficiency, cultural insensitivity of providers – obstacles to care

Limited education/literacy

- Less likely to have completed education beyond high school
- Many do not read English well or are unable to read at all

Lack of social supports

- Far from place of origin, seeking jobs, services or respite from abuse
- Alienated from family and friends, stigmatized, isolated

Criminalization of homelessness

- Arrests for activities that are permissible within the privacy of a home
- Medications often confiscated during arrest, not returned
- Criminal record an obstacle to employment, housing, services

*From Adapting Your Practice: General Recommendations for the Care of Homeless Patients Health Care for the Homeless Clinicians' Network. Available at www.nhchc.org.
See expanded version of this document in the Shelter Health toolkit.*

Understanding the Connections Between Poor Health and Homelessness

In communities nationwide, projects providing primary care to homeless people seek to disrupt the terrible nexus between poor health and homelessness. As of June 2005, 177 HCH grantees of the Health Resources and Services Administration (HRSA) were providing health and social services to more than 600,000 clients per year. These projects typically operate as part of Community and Migrant Health Centers, hospitals, or Departments of Public Health, or as freestanding agencies. Most combine HRSA funding with other revenue and grants to provide a broad range of services.

At a minimum, each project provides a prescribed set of required services, including primary health care and substance abuse services, emergency care and referrals, outreach and assistance in qualifying for entitlement programs and housing. Many HCH projects go well beyond these basic services, offering dental care, mental health treatment, subacute recuperative care, supportive housing, and other services needed to resolve their clients' homelessness.

To engage homeless persons and to provide effective care, HCH projects utilize a number of approaches that accommodate the realities of homelessness. These include:

- **Outreach.** HCH physicians, nurses, social workers and others skilled at making connections with homeless people (often including persons who have experienced homelessness themselves) seek out and bring care to homeless people wherever they are—in encampments, under bridges, on the streets, in jails, at soup kitchens and other service sites.
- **Service locations.** HCH clinics are located in or near shelters and other places where homeless people congregate.
- **Service hours.** Many HCH projects operate during extended hours to accommodate the schedules of clients who work or must be elsewhere at certain times to secure food or shelter.
- **Transportation.** HCH projects frequently provide transportation to and from clinics, specialty providers, Social Security or Food Stamp offices, and shelters.
- **Elimination of financial barriers.** HCH projects assure that inability to pay even a small fee does not become a barrier to receiving health services.
- **Sensitivity.** HCH staff endeavor to understand the unique circumstances and stresses associated with homelessness. They understand that the process of engaging individuals

The Housing Shortage

The US Department of Housing and Urban Development reports 5 million extremely poor households paying >50% of income for housing or living in severely substandard housing.

In no US jurisdiction can a full time worker earning minimum wage afford an apartment at fair market rates.

National Low Income Housing Coalition

who are homeless often involves overcoming significant fear and suspicion, and that a patient, nonjudgmental, persistent approach is often required.

- **Comprehensive services.** HCH providers understand that health care and other basic needs are interrelated, and strive to address each client's needs holistically through the use of multidisciplinary clinical teams. Integration of primary care with the treatment of mental health and substance use disorders is a hallmark of HCH practice, and efforts to secure housing, entitlements, and jobs are intrinsic to this approach.
- **Case management.** Coordination of a wide range of onsite and referral resources receives particular attention in the HCH approach to care.
- **Clinical adaptations.** To promote favorable clinical outcomes, HCH providers have developed techniques such as prescribing simple medical regimens with few side effects, or screening for common problems during the first encounter with a client.
- **Advocacy.** HCH staff engage in advocacy to secure client services, to protect clients' rights, to affect the local service delivery systems so that it better meets the needs of their clients, and to change policies that cause, exacerbate, or create obstacles to resolving homelessness.
- **Client involvement.** HCH projects are careful to involve their clients in developing realistic treatment plans, in the governance of their agencies, in evaluating the efficacy of homeless services, and in advocating for service improvements and policy change.

The Health Care for the Homeless Program employs a model of care that is appropriate for everyone, but is particularly well adapted to the circumstances of those most in need. By creating numerous new service delivery sites and modalities, the HCH Program has contributed importantly to the development of the health care infrastructure in the United States. In that respect, HCH is far more than a safety net.

Yet for those whose personal circumstances have reduced them to homelessness and for whom all other systems have failed, HCH remains the final safety net. The quality of care available through Health Care for the Homeless improves the health and well-being of displaced people and models for all service providers a high standard of care.

Life expectancy

US Population:	77 years
Homeless in Boston:	47 years
Homeless in Atlanta:	44 years
Homeless in San Francisco:	41 years

*O'Connell JJ. Premature Mortality in Homeless Populations:
A Review of the Literature, Nashville: National Health
Care for the Homeless Council, Inc., 2005*

The HCH approach to care described above is one that can be adopted or modified by a variety of community service providers—disaster shelters, long-term homeless shelters, public health departments—to meet the health needs of displaced persons.

John Lozier

Human Rights, Shelter and Health Care

The Universal Declaration of Human Rights, adopted by the United Nations in 1948, proclaimed that “everyone has the right to a standard of living adequate for the health and well-being of oneself and one’s family, including food, clothing, housing, and medical care.”[1]

This statement of principle was adopted at the urging of the United States,[2] and proclaims the truths of our nation’s founding documents.[3] However, widespread homelessness and the lack of health care for millions of Americans is evidence that these principles have not yet been implemented in the United States. Indeed, the United States is one of only seven United Nations member States that have not ratified the International Covenant on Economic, Cultural and Social Rights, a legally enforceable treaty that protects the rights to living wages (Article 7), social security (Article 9), an adequate standard of living, including food, clothing, housing (Article 11), “the highest attainable standard of physical and mental health” (Article 12), and education (Article 13). For elaboration on these topics, the Shelter Health Tool Kit contains informative articles entitled “The Right to Health in America” and “Homelessness in the United States and the Human Right to Housing.”

Less well established but very important principles of international law address the rights of Internally Displaced Persons.[4] Persons who are forced to leave their home areas because of armed conflicts, human rights violations, or other natural or human-made disasters, but who stay within their national borders, are considered Internally Displaced Persons (IDPs). Human Rights principles declare that such persons enjoy the same rights as other citizens, and that governments are obligated to provide for the protection of their rights to housing, health care, education, etc. Moreover, particular protections, such as the right to return home, apply to IDPs, as described in an article on “Hurricane Katrina and Internally Displaced Persons” published by the American Society of International Law and found in the Tool Kit.

In the context of emergency shelters, it is important to recognize the rights of shelter residents. At the most basic level, shelter residents have the right to be treated with respect, whether their homelessness results from a natural disaster like a hurricane or from long-term social, economic and personal problems. The opportunity to be heard is an essential component of respectful treatment; shelter operators should establish procedures for redressing grievances and appealing decisions that affect the residents, and should make the procedures known to residents. The Toronto Shelter Standards in Section F of the Tool Kit are appropriately sensitive to the rights of shelter residents.

Likewise in health care, patients have rights that must be respected by providers of care. Chief among these are the rights to be informed about one’s health status, to participate in decisions regarding treatment, and to protection of one’s privacy and the confidentiality of treatment relationships. These rights are not abridged by one’s economic or housing status.

Care providers, including volunteers and paid staff, also have rights that must be recognized and protected by shelter operators and by shelter residents. Among these rights are the right

Shelter Health:
Essentials of Care for People Living in Shelter

to be treated with respect, to work in a safe and healthy environment, to have the tools and resources necessary to accomplish their jobs, to earn a living wage, to appeal adverse decisions and to form labor unions.

Finally, it is incumbent upon all involved in to help assure the basic human rights described in international law. Unlike the Economic, Cultural and Social Rights discussed above, Civil Rights to free expression and participation in the political process are well-established in the United States.

[1] Universal Declaration of Human Rights [UDHR], Article 25(1).

[2] First Lady Eleanor Roosevelt chaired the UN Human Rights Commission that drafted the UDHR.

[3] The Declaration of Independence: “We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable rights, that among these are life, liberty and the pursuit of happiness. That to secure these rights, governments are instituted among men, deriving their just powers from the consent of the governed. That whenever any form of government becomes destructive to these ends, it is the right of the people to alter or to abolish it, and to institute new government, laying its foundation on such principles and organizing its powers in such form, as to them shall seem most likely to effect their safety and happiness.” cf. Also the Bill of Rights and additional amendments to the Constitution of the United States.

[4] See the *Handbook for Applying the Guiding Principles on Internal Displacement*, a 1999 publication of the Brookings Institution Project on Internal Displacement, at http://www.reliefweb.int/ocha_ol/pub/IDPprinciples.pdf

John Lozier

Thinking of Hosting a Homeless Shelter?

Does your church or community group want to host a homeless shelter? What do you need to know to make it work for everyone involved?

THE NEED

Homelessness is a growing problem. Almost no community has enough shelter or services to fill even the existing need, let alone what will present tomorrow. Long-term solutions include preventing homelessness and helping people who are now homeless become more self-sufficient, at an income level with a margin for future emergencies. But in the meantime there are women, children and men who need warmth and safety tonight, or they aren't going to benefit from long-term solutions.

Many community organizations have some empty space that is not used at night, and are contemplating opening it for some form of homeless shelter. Seattle's oldest church, First United Methodist, hosts a large number of community services, in almost every existing space. The Church of Mary Magdalene and Mary's Place, a day program for homeless women, use their lower floor; at night it is used by Compass Cascade service agency as a shelter for homeless men. One of their upstairs rooms, Drury Hall, is used by Columbia Senior Citizens Club during the day, and was the original site of a homeless women's shelter for severe weather.

Seattle has more homeless shelters than almost any other city its size, but still has approximately 2,500 men, women and children unsheltered each night. I have been involved in opening several shelters. I offer this article summarizing what I have learned.

BASIC REQUIREMENTS

Whatever type of homeless shelter you decide to host, you will need several basics:

Space

There are shelters in Seattle that host as few as 5 people, and others that host as many as 100. Every bit helps, so even if you have a small available room, you may consider opening a shelter. Having clear floor space, however, is essential. Folding tables and chairs can be put away at night and set up again in the morning. A room with heavy or built-in furniture probably isn't usable.

Available use at least 10 hours on a fairly set schedule

You want to allow the people who use the shelter at least eight hours of sleep, with time to get in and settled at night, and time to get ready to leave in the morning. Also allow cleaning time between the day's activities and the shelter opening, and between the shelter closing and the next day's activities. In most hosted shelters, there are occasional activities that require the shelter to open an hour late, or close an hour early. If the shelter hours fluctuate constantly or are consistently less than eight hours, however, it's not going to be workable.

Restroom

We would all like to be able to offer homeless people real beds, showers, laundry, kitchen facilities and a place to store their belongings. This usually isn't within a church's resources.

Shelter Health:
Essentials of Care for People Living in Shelter

A mat on the floor with two blankets sounds grim, but it is a lifesaver, compared with the alternatives. Having bathroom facilities, however – a toilet, sink and soap – are a minimum necessity and required by health code.

Storage

You will need some storage space for the mats, bedding, cleaning supplies, and whatever else the shelter uses exclusively for itself.

Security

For the sake of both your church and the members of the shelter, the area used by the shelter should have a separate entry and closed doors between the shelter space (including restrooms and supply storage) and the rest of the church.

Manageable space

It is much easier to manage a shelter if it is one continuous space, with all parts visible from any point in the room. I am not implying that homeless people need to be watched like a hawk at all times. But you probably wouldn't feel comfortable if you were hosting a luncheon in which 50 people were scattered in individual nooks over three separate rooms; you'd have to run your feet off making sure everybody had what they needed, and you would undoubtedly need help. If you don't want to be housing more staff members than homeless people, find a room that's easy to manage.

A managing agency

You may want to open your shelter yourself and staff it with volunteers from your church. Or you may feel more comfortable forming a contract with another group that is experienced in operating shelters, with you providing space and some volunteer help and they providing management.

Insurance

If you partner with another agency, they will usually pay for the extra insurance your insurance company – and local government – will require for the shelter. Otherwise, you will have to provide this yourself.

Supplies

Even for a bare-bones shelter, some supplies will be needed: toilet paper, cleaning supplies, light snacks and coffee.

Blanket washing

If another agency is managing the shelter for you, they can arrange this. Making sure it is done, though, should be part of your contract with them.

Public notice, or referrals?

Announcing that your shelter is open and waiting for people to come to your door may be frustrating if no one comes, or overwhelming if you aren't prepared for who does. Most churches prefer to let service agencies refer people in need: the agency will often have a pretty good idea of who will do best where, and can also provide transportation (at least a bus ticket) to and from the shelter.

Who does your congregation feel most called on to serve?

Do you want to provide an all-woman shelter? A shelter for families with children? A shelter for couples? A shelter for youth? A shelter open to both single men and single women (with separate sleeping areas)? A shelter for men only? A respite shelter for people with illnesses or injuries that require bed rest but not hospitalization or nursing care? What is within your capabilities? The decision about which group you want to serve will influence your choice of which agency you want to partner with.

CHOOSE A SHELTER MODEL

There are several shelter models:

Staffed shelter

This is the traditional shelter, with professional paid staff. It is the most expensive model. Some agencies that will be willing to run a staffed shelter will want a space where they can set up beds, showers, and other amenities.

Volunteer staff

Many local shelters run smoothly with a rotating staff of volunteers. Local service agencies send referrals, with blankets. The church provides space, including bathroom facilities and storage for mats. The volunteers provide light snacks and supervision. The shelter members set up their own mats and clean up after themselves.

Self-managed shelter

SHARE, the Seattle Housing and Resource Effort, is a group of homeless and formerly homeless men and women who organize their own self-managed shelters and other survival resources, while doing self-advocacy for the social changes to end homelessness. Some other cities have groups like SHARE.

SHARE has fourteen shelters hosted by churches and other community groups. The key to the shelter space is kept in a central location. Each night, a responsible shelter member picks up the key, the shelter record book, and bus tickets for shelter members. The shelter members go to the shelter, let themselves in, and set up for the night. They govern themselves according to agreed upon rules. In the morning, they clean up after themselves and let themselves out. Shelter supplies are provided by SHARE. Once a week, volunteers from the shelter wash the blankets with transportation and laundry facilities provided by SHARE.

Mixed model

A number of shelters run on a mixed model, with both staff and volunteers, or self-managed with one staff member or a volunteer present to facilitate.

Day center

If you have a room available even for only a few hours of the day, just being able to come indoors, sit down, have a cup of coffee, browse the papers and chat is a blessing. Being out on the streets from the time the night shelters close at perhaps 6:30 AM to when they open at perhaps 9 PM is a physical hardship on almost anyone. The isolation of homelessness is as much of a hardship.

FUNDING

The level of funding needed will depend on the model of shelter you choose and the level of services you want to offer. Self-managed emergency shelters cost approximately \$3 per person per night. Our mixed-model mats-and-blankets severe weather shelter costs approximately \$6.50 per person per night. A professionally staffed shelter offering beds, storage, phones, meals, showers, laundry and case management counseling can cost \$40 per person per night.

Sources of funding may be your own church budget, special fund-raising among your donors, or, if you partner with a non-profit shelter management organization, a cooperative fund-raising effort that may include private and public grants. The federal government funds homeless shelters through both the McKinney fund and FEMA (Federal Emergency Management Act.)

State, county and city governments also fund homeless services. Social service agencies in your local area will be able to tell you who to apply to for what sources of funding, and what local regulations apply. Many areas have a Coalition for the Homeless, an association of service agencies; check your local listings, or check the [National Coalition for the Homeless](#) website, to find them.

CLEAR RULES & EXPECTATIONS

Whichever model of shelter you decide to use, establish rules ahead of time that you expect the shelter to follow.

The standard minimum rules for SHARE shelters are: no alcohol, drugs or weapons on the premises; no one is admitted if drunk or high; no violence is tolerated. The purpose of severe weather shelters is to get people inside during life-threatening conditions, so they have relaxed standards on being drunk or high; this requires more staffing at such shelters. Most shelters have the same minimum rules.

SHARE also requires those who use the shelter to participate in governance and maintenance of the shelter, and to take some part in other SHARE community activities such as the all-shelter organizing meetings. Other shelters may have requirements such as participation in church services or case-management programs.

Each shelter also has specific rules worked out with an individual host. Some SHARE hosts, for instance, want more personal involvement with the shelter: they have set up a schedule of regular potluck dinners where shelter and community members mingle, and community projects like neighborhood cleanups that both shelter and congregation participate in.

One church has bathrooms down a hall which leads past a steep stairway, and requires that residents using the bathroom have a staff escort for both security and safety reasons. Some churches are uncomfortable hosting co-ed shelters, and if they host shelter for couples or families, require proof of marriage. These are the kinds of things that you should work out ahead of time with whoever will manage your shelter, even if it is members of your own congregation, so that everyone is clear on the expectations.

CONTACTS

Set up contact persons for emergencies, problems or complaints. Ideally, set up a regular schedule of meetings to touch bases, see how the shelter is going, and make any changes that are needed as time passes. In the shelter space that Drury Hall uses, for instance, there are two couches. Since the staff members sleep in shifts, some began sleeping on the couches, since the agreed upon rules didn't forbid it. This upset the church maintenance staff, so the rules needed to be changed.

NEIGHBORHOOD MEETINGS

It is also a good idea to have neighborhood meetings ahead of time, and work out agreements with your neighbors, without compromising your right to provide the service you feel called to give. Assurances that shelter residents are not going to use parking space or smoke underneath neighborhood windows, for instance, and that extra garbage pickups will be done as necessary, will help acceptance of the new neighbors.

No matter how loud, fearful or angry your neighbors sound at first, I can tell you from experience that after they have lived side by side with real homeless people for a few months, a lot of them will be offering help to the shelter. You can speed this process the more you offer opportunities for involvement.

ONCE YOU'VE STARTED

New things will always come up, once the shelter is operating. That's life. Having worked out the plan this far, though, you'll be prepared to handle them.

Adapted from article by Anitra L. Freeman <http://anitraneb.org/homelessness/faqs/helping/hosting.html>

Shelter Health:
Essentials of Care for People Living in Shelter

What You Need to Know

Shelter Health:
Essentials of Care for People Living in Shelter

Bringing Health Care into the Shelter

Learning Goal:

- To identify common health conditions found among people living in shelter and become familiar with effective responses to those conditions.

Anyone experiencing homelessness for any length of time faces many barriers to accessing basic health care services: lack of health insurance, lack of transportation, lack of stable income to pay for medications. Homeless individuals and families are often so consumed with obtaining the basics of food, shelter, and clothing that physical and mental health needs become lower priority. While health problems can be both a cause and a result of homelessness, they too often go unaddressed.



Just as homeless individuals are too overwhelmed by immediate needs to address longer-term health issues, so too are shelters – which often come into existence to meet the immediate and overwhelming need to keep a roof over people’s heads, and are often too consumed by the day-to-day logistics of shelter operations even to consider whether or how to address the health care needs of shelter residents.

In spite of these realities, it is critical that shelters work to address the basics of safety and environmental health, and to begin exploring ways to bring more substantive primary care services to the people they serve. This section of the guide will attempt to give an overview of the common health conditions among homeless people and to lay out some strategies for organizing shelter health services.

The Tool Kits

At the beginning of each section of this Guide, readers will find lists that outline the contents of the Tool Kits that can be found in electronic form on the CD that accompanies this Guide. While some of the tools and handouts are found both in the Guide and in the Tool Kits, most of the items listed below are only found in the Tool Kits. They are to be used to supplement the material in the Guide and to provide shelter providers with day-to-day tools for use in the shelters.

Tool Kit B: Bringing Health Care into the Shelter

- B-1 Adapting Your Practice: General Recommendations for the Care of Homeless Patients (HCH Clinicians' Network)
- B-2 CDC handout: Controlling the Spread of Infections
- B-3 CDC handout: Diabetes Flyer
- B-4 CDC handout: Keep It With You Medical Info Form
- B-5 CDC handout: Cover Cough (English)
- B-6 CDC handout: Cover Cough (Spanish)
- B-7 MCN handout: Daily Foot Care
- B-8 MCN handout: Depression and Healthy Living
- B-9 MCN handout: Healthy Foods
- B-10 MCN handout: Small Changes
- B-11 "Healing Hands" February 2005: Bugs That Bite
- B-12 "Symptoms of Diabetes"
- B-13 Fact Sheets from *The Health Care of Homeless Persons* (English and Spanish)

The Facts on Common Health Conditions

The following pages contain a number of fact sheets on specific acute and chronic diseases that are of particular concern to people living in shelter. They were originally printed, with full color illustrations, in *The Care of Homeless Persons: A Manual of Communicable Diseases and Common Problems in Shelters on the Streets*, Jim O'Connell, MD, editor.

While the following selected fact sheets do not paint a complete picture of the common health needs of homeless persons, they do present many of the health issues that are of greatest concern to shelter providers. They include:

- Influenza
- Upper Respiratory Infection (the common cold)
- Diarrhea
- Hepatitis A
- Hepatitis B
- Hepatitis C
- Tuberculosis
- HIV/AIDS
- Vaccinations
- Lice
- Scabies

These and many others can be found in both English and Spanish in the hard copy of the *Manual of Communicable Diseases* provided with this Guide, on the CD provided with this Guide, or at: www.bhchp.org/BHCHP%20manual/pages/factsheets_as_pdf.html

Influenza

What is influenza?

Influenza is the flu, a virus that comes around once a year, usually in the late fall or winter months.

When you have the flu, you get a fever, chills, headaches, dry cough, and often a runny nose. You feel very tired and can feel achy all over for several days.

For most people, the flu comes and goes quickly. But the flu can make you very sick if you have problems with your heart or lungs. You can also get very sick from the flu if you are infected with HIV, the virus causing AIDS.

How do you get the flu?

The flu is easy to catch when many people live close together. You get the flu by breathing germs from someone who coughing or sneezing or by staying in a shelter where many people are sick.

What should you do if you get the flu?

If you have the flu, you should take it easy and drink plenty of liquids. You can help a sore throat by gargling with warm water and some salt.

Use Tylenol™ (acetaminophen) to treat the fever or muscle aches.

You should see a doctor or nurse if you are getting worse, are not better after a few days or if you have heart or lung problems.

How can you keep from getting the flu?

You can get a flu shot every year so you don't get the flu or give it to other people. Shelters usually give flu shots in November.

You can't get the flu from a flu shot. Most people don't have any side effects from the flu shot. However, sometimes, the shot can make you feel achy and tired, or you may have a low fever and chills. This is not common and only lasts for about 2 days. Your arm may be sore for a couple of days from the shot.

If you are allergic to eggs, you should not get a flu shot.

If you are ill and have a fever, wait until you feel better before you have a flu shot.

You should wash your hands with warm water and soap after blowing your nose or your child's nose to prevent giving the flu to others.

Originally published in The Health Care of Homeless Persons.

Upper Respiratory Infection (URI/Common Cold)

What is an upper respiratory infection?

Upper respiratory infection is a medical term for the common cold. People get colds all the time. Adults can get 2 to 4 colds every year. Children can get as many as 6 to 8 colds every year.

How do you get a cold?

Colds are most likely spread when people cough or sneeze germs into the air, and then other people breathe those germs. Also, people with colds may touch their noses and then put their hands on other people or things like toys.

What are the signs of a cold?

If you have a cold, you may cough, have a stuffed and runny nose. You sneeze and your throat is sore. You may feel pressure in your ears.

Adults can sometimes have fevers up to 101°F (38.3°C). Sometimes, children can get a fever up to 102°F (38.9°C).

What do you do if you have a cold?

You should get rest and drink plenty of water or any type of fluids. If you have a sore throat, mix some salt in warm water and then gargle. You can also use throat lozenges.

If you feel sore everywhere, you can take Tylenol™.

Decongestants may help a stuffed or runny nose.

If you have a high fever, what do you do?

- If you or your children have a high fever (over 102° F/38.9°C), see a doctor or nurse immediately.
- If you have a fever, swollen glands, and a sore throat see a doctor or nurse immediately.
- If you have a fever and cough up yellow or green phlegm, see a doctor or nurse immediately.

How do you keep from spreading a cold?

If you or your children have a cold you should wash your hands often, (especially after blowing noses or wiping secretions) and throw the tissue away.

People without colds should also wash their hands a lot with warm water and soap, particularly before preparing, serving or eating food.

Originally published in The Health Care of Homeless Persons.

Diarrhea

What is diarrhea?

Diarrhea is usually a change in a normal bowel pattern, with abnormal amounts of stool or liquid stool. You can get diarrhea from viruses, bacteria, or parasites. You can also get diarrhea from other medical problems.

What happens when you have diarrhea?

If you have diarrhea, you have to go to the bathroom a lot. Your bowel movements are loose and mixed with liquid. Sometimes, you get cramps, you throw up, or you have a fever. You may see blood or mucous in your bowel movements. When diarrhea lasts for more than three days, or if it seems severe, see a doctor or a nurse. They can take a sample of your bowel movement to see what kind of diarrhea you have.

What do you do if you or your child has diarrhea?

Whenever you have diarrhea, drink a lot of clear liquids to replace the fluids you have lost. If your baby has unusually loose stools or an increase in the usual number of bowel movements, contact your health provider. Diarrhea can quickly make babies very sick.

If your child has diarrhea, special liquids, such as Pedialyte™ or Enfalyte™, which can be obtained from a drug store, can help prevent your child from becoming dehydrated. If the diarrhea is not severe and the child is not vomiting, you should allow the child to eat a normal diet in moderation. Keep in mind that starchy foods are better absorbed. If your child's diarrhea is severe or won't stop, contact a doctor or nurse.

Take your child to a hospital or clinic if you see any of these signs:

- your child can't make tears;
- the mouth of your child is dry;
- the eyes of your child look sunken or have dark circles around them;
- your child is very sleepy;
- your child is less than 12 months of age and is having very large or very frequent stools;
- your child has not wet a diaper in 8 hours.

If your child has diarrhea, vomits, or has a fever over 101°F (38.4°C), see a doctor or nurse.

How do you keep from getting diarrhea?

Always wash your hands:

- before fixing any food or formula;
- before eating or feeding a child;
- after changing diapers or going to the bathroom.

Toilet-trained children should always wash their hands after they go to the bathroom. You or another adult should remind children to wash their hands and watch them in the bathroom. If children are putting toys in their mouths, try to keep them from sharing these toys with other children. This is especially important if one of the children is sick.

If you have diarrhea, do not fix or serve food to anyone outside of your family. You can serve and fix food when your symptoms go away or your doctor or nurse tells you it's OK.

Originally published in The Health Care of Homeless Persons.

Hepatitis A

What is hepatitis A?

Hepatitis A is a virus that irritates your liver.

People with hepatitis A can feel very tired and have a fever, poor appetite, nausea, yellow eyes and skin, dark urine, and white bowel movements. Some people, especially children, don't have yellow skin or eyes. You usually feel sick from hepatitis A for about 2 weeks, although some people can get sick for several months and others never get sick at all.

How do you get hepatitis A?

Hepatitis A is spread through the stool of infected people. This can happen when an infected person goes to the bathroom, doesn't wash his hands, and then touches objects which others might put into their mouths. Hepatitis A can spread when you change diapers or when children put their hands into their diapers and then touch objects that go into the mouth.

You can't get hepatitis A when you talk to, touch, or sleep in the same room with a sick person.

How do you treat hepatitis A?

There is no treatment for hepatitis A. If you get sick, lots of rest and high calorie foods can make you feel better.

How can I keep from getting hepatitis A?

If you are at high risk for getting hepatitis A or may get seriously sick from hepatitis A, you can get a vaccination. This vaccination is for sexually active men who have sex with men, illegal drug users (injection and non-injection drug users), persons with chronic liver disease, and children living where there are high rates of hepatitis A.

Whether or not you are vaccinated against hepatitis A, it is always important to wash your hands before you touch food, eat, feed your baby, change your baby's diapers, or go the bathroom. Always put soiled diapers in a wastebasket that children can't get into.

If your children get hepatitis A or the person you live with has hepatitis A, you can get a shot called immune globulin (IG) to make sure you don't get very sick. The shot has to be given within 2 weeks of exposure, so see a caregiver as soon as possible.

Can you get hepatitis A more than once?

After you get sick from hepatitis A, you can't get it again. But remember, you can still get other types of hepatitis.

Originally published in The Health Care of Homeless Persons.

Hepatitis B

What is hepatitis B?

Hepatitis B is a virus that affects your liver. The early symptoms are like the cold or flu. After about a month, your skin may turn yellow and begin to itch. Your urine looks like Coca-Cola, but the color of your bowel movements is light. You may not see any of these symptoms for a month-and-a-half to 6 months after you first get the disease.

These symptoms can last for 1 to 2 months. Usually, you are healthy again after the symptoms go away. Some people die from hepatitis B, and others have lifelong liver problems.

What do you do if you have hepatitis B?

Rest and high calorie foods may help your fever and itching. Usually, food goes down better in the early part of the day. Avoid drugs such as Tylenol™ that are broken down by the liver. Alcohol and illegal drugs can also damage the liver.

How do you get hepatitis B?

The virus doesn't spread when you talk to, touch, or sleep in the same room with an infected person. Having sex without a condom or sharing needles with an infected person can spread the virus very easily. Some people can be infected and never feel or look sick, however, they can still spread the virus.

How do you keep from getting hepatitis B?

Vaccination can prevent you from getting hepatitis B. It is now recommended that all children and adolescents receive the hepatitis B vaccine. The vaccine is also recommended for adults who are high risk, which includes injection drug users.

If you inject drugs, you can also keep from getting hepatitis B by not sharing needles. If you share needles, use a watered down bleach solution to clean your works before and after you shoot to kill the hepatitis B on the needle. Ask shelter staff about where to find bleach.

Use a condom every time you have sex. Often, shelter staff know where you can get condoms.

Don't share toothbrushes and razors.

Cover any cuts or sores with a bandage.

If you touch any of the fluids that come out of another person's body, especially blood and urine, you need to wash your hands very well.

Be careful when throwing away razors and other sharp things! The shelter staff can tell you where to put them.

Watch children to make sure they don't bite or scratch one another.

If you get exposed to hepatitis B, ask your doctor or nurse about vaccines.

Originally published in The Health Care of Homeless Persons.

Hepatitis C

What is hepatitis C?

Hepatitis C is an RNA virus (a type of germ) that causes liver disease. The hepatitis C virus is found in the blood and liver of people with hepatitis C infection.

How is hepatitis C spread?

The virus is spread primarily through blood. People most at risk are those who have had a blood transfusion or an organ transplant before 1992, or people who use or have used needles contaminated by blood (for example, the injection of drugs). Since July 1992, the blood supply has been carefully checked for this virus and the blood supply is considered to be safe.

The hepatitis C virus can be spread whenever blood (or fluids containing blood) comes in contact with an opening on the skin or other tissues. This can occur even when these openings cannot be seen. Hepatitis C virus can also be transmitted by sexual contact, but this does not happen as easily as the spread of HIV, the virus that causes AIDS. Tattooing and body piercing are also risk factors.

The hepatitis C virus is not spread by casual contact like hugging, sneezing, coughing, or sharing food. As with all blood born infections razors, toothbrushes and drinks should not be shared. You cannot get hepatitis C by donating blood.

How serious is hepatitis C?

Hepatitis C infection can be very serious. Most people who become infected will carry the virus for the rest of their lives. Some of these people will develop liver damage and feel very sick. Other people may feel healthy for many years after being diagnosed with hepatitis C infection. This virus can eventually cause cirrhosis (scarring of the liver) and/or liver cancer in some infected people. While most people will not develop liver failure or cancer with hepatitis C, a significant number of people will. We cannot tell who will or will not have these problems. We do know that the homeless and poor patients are at higher risk for infections and complications.

Who is at risk for getting hepatitis C?

People are at risk for developing hepatitis C infection if they:

- have used street drugs or shared needles, even just once;
- have received a blood transfusion, blood products, or an organ transplant before July 1992;
- have had many sexual partners, especially if they did not use condoms;
- are health care workers (like doctors or nurses) who may be exposed to blood or needles;
- are babies born to mothers who have hepatitis C;
- are homeless;
- suffer from alcoholism;
- are veterans of the Vietnam war;
- have tattoos or body piercing with infected needles or ink;
- have been on kidney dialysis.

Continued on next page.

Is there a treatment for hepatitis C?

A drug called interferon, in combination with Ribavirin™, is used to treat hepatitis C infection. People diagnosed with hepatitis C infection should not drink any alcohol or take certain medicines that can cause liver damage. It is recommended that persons infected with hepatitis C be vaccinated for hepatitis A and hepatitis B, two other viruses which cause liver damage if they are at risk for those infections. Antibiotics (medicine to fight an infection from bacteria) do not work against the hepatitis C virus. Ask your doctor about treatment options and steps you can take to protect your liver.

How can hepatitis C be prevented?

There is no vaccine for hepatitis C. The best way to keep from getting the hepatitis C virus is to avoid any contact with blood. This includes not sharing needles, razors, or toothbrushes. Blood banks now screen donated blood for hepatitis C virus, so your risk of getting infected from a blood transfusion is extremely low. You can also get hepatitis C from sex with an infected partner; using a condom may reduce your risk of becoming infected.

To prevent the spread of hepatitis C:

- if you shoot drugs, never share works with anyone. Don't share cocaine or other snorting straws, since these can get blood on them too. Find out about treatment programs that can help you stop using drugs.
- use a latex condom every time you have sex.
- only get tattoos or body piercing from places using sterile equipment.
- health care workers and people who clean up in hospitals or places where needles or sharps are used should follow standard (universal) precautions for every patient.
- if you have hepatitis C, don't share razors or toothbrushes.
- if you have hepatitis C, don't donate blood, sperm, or organs.

*Adapted from the Massachusetts Department of Public Health Fact Sheets
Originally published in The Health Care of Homeless Persons.*

Tuberculosis (TB)

What is tuberculosis?

Tuberculosis, or TB, is a germ that most often infects your lungs. It can also grow in other parts of your body. TB of the lungs can make a person sick with cough that doesn't go away, fevers, sweats at night, and weight loss.

How do you get TB?

TB spreads when someone sick with TB in the lungs coughs or sneezes. This puts the germs into the air, and then other people breathe them. If you spend a lot of time near a person who is sick with TB, you can get infected. Most people who get infected with TB do not get sick; their immune system keeps the infection in check, and the person doesn't know that he or she is carrying the TB germ.

How do you know if you have TB?

To be sure you don't have TB infection, you can take a skin test called the "PPD." If you are at risk for TB, you can take the skin test every 6 months. This test shows if you have TB germs in your body. If you have TB germs, the test is "positive." To be sure that these germs are not making you sick, a physical exam and a chest x-ray usually are needed.

What do you do if you have TB?

If your test is positive, get a check-up and a chest x-ray to see if the germs are making you sick. Your TB germs may not be making you sick right now. But they can make you sick at anytime in your life. The doctor can give you an antibiotic to kill the germs so they don't begin to grow and make you sick.

If you are infected with TB, but not yet sick, you cannot spread the germs to other people. If you are sick with TB, it is possible that you can spread the disease to other people. Your friends may need to take a PPD skin test to make sure they are not infected.

If you are sick with TB, you will need to take TB medicine for many months before all of the germs are killed. You should take the medicine even if you feel better. TB germs can hide out until the medicine is not around. Then, the germs grow back and make you sick again.

It isn't easy to take medicine in shelters. Ask the shelter staff about a safe place to store the pills. Ask someone to help you to remember to take your pills. The Health Department should be able to help you with your medicines.

Sometimes the TB medicine can cause side effects. You may have a fever and a skin rash. You may not want to eat, or your stomach may get upset and you throw up. The right side of your stomach may be sore. Your skin and eyes may turn yellow and your urine may look dark, like tea. This means the medicine is hurting your liver. If you see any of these signs, stop the pills immediately and see your doctor.

Originally published in The Health Care of Homeless Persons.

HIV and AIDS

What is HIV?

HIV is a virus that spreads through sexual contact and blood contact. The virus can also pass from a pregnant woman to her unborn baby or to a baby through breast milk.

What is AIDS?

AIDS stands for “acquired immune deficiency syndrome.” AIDS results when the body’s immune system is damaged by the human immunodeficiency virus (HIV). This can result in infections and certain kinds of cancer. AIDS can be prevented!

How is HIV transmitted?

HIV is a virus that is spread through person to person contact with body fluids – blood, semen, vaginal fluids or mother’s milk.

The virus is most often transmitted during sexual contact, through sharing needles and other drug works. It can also be passed to a baby during pregnancy or at birth.

Sexual contact can be between men and women or between partners of the same sex.

How do other sexually transmitted diseases affect HIV?

When a person has another STD like gonorrhea, Chlamydia or herpes, he or she is at greater risk of getting HIV.

How can I tell if my partner has HIV?

There is no way to tell if a person is infected with HIV. He or she can look healthy and feel healthy.

How can I tell if I have been infected with HIV?

When a person is initially infected with HIV, he or she may have fevers, chills, swollen lymph nodes and a rash. This usually resolves in several days. People with HIV may not know it. They may feel and look very healthy. They can still spread the virus. The only way to find out is to have HIV testing done either by a saliva sample or a blood sample.

Does a positive HIV test mean I have AIDS?

No. It means you have been infected with the virus. Treatment with medication may prevent the development of AIDS. If your HIV test is positive, you can spread the virus to sexual partners, needle use partners or your unborn child.

What do I do if I am pregnant and may have HIV?

If you are pregnant or planning to become pregnant, consult your doctor about getting a test for HIV. If you are HIV positive, your doctor can help you and your baby if you get into care as soon as possible.

Continued on next page.

What do I do if I am HIV positive?

It is important to remember that HIV is now a treatable disease. Get medical care as soon as possible. If you do not need medications, it is important to stay as healthy as possible and to get regular check ups.

What do I do if someone I know is HIV positive?

People with HIV need support and understanding, as well as respect for their confidentiality. If someone tells you he or she has HIV, offer friendship but respect their privacy.

How can I keep from getting HIV?

You can become infected if you do not practice safer sex. Men should always wear a condom (rubber). Lubricate the condom with water-based substances such as K-Y Jelly™, For-Play™, PrePair™, or Probe™. Don't put any oil or Vaseline™ on the condom because it may break. Avoid nonoxynol 9 spermicide. Never use a condom more than once. Don't take chances. Use a condom from start to finish every time you have sex.

Oral sex on a man should also be done with a condom in place. For oral sex on a woman, use a dental dam. Don't let blood or sexual fluids enter your mouth or your partner's.

Dry kissing, masturbation, hugging, and touching are safe. Deep (French) kissing has not been shown to pass on the virus but may be risky, especially if there are sores or blood in someone's mouth.

DON'T SHOOT DRUGS! The best protection from HIV is to get help through a drug program. When using drugs, **NEVER SHARE NEEDLES**, straws, or other works. Always clean your works with bleach before and after use.

Because HIV spreads through blood, don't share sharp objects like razors and toothbrushes that may have blood on them.

You cannot get the virus by being stung by insects, sitting on toilet seats, washing dishes, or being around someone with AIDS. Sharing bathrooms, dishes and laundry cannot spread the virus. A person infected with HIV cannot transmit the virus when he or she hugs and touches you or sneezes towards you.

Where can I get information about HIV/AIDS?

Much information about HIV/AIDS is now available. The shelters have brochures and sometimes videos. There are now many magazines with information about HIV/AIDS. If you have access to the internet, the following websites can give you information that is easy to understand:

www.projectinform.com
www.thebody.com
www.aegis.com

Originally published in The Health Care of Homeless Persons.

Vaccinations

What is a vaccination?

When you get a shot to protect you against a certain disease, you are getting a vaccination.

In the USA children routinely get shots to protect them against measles, mumps, rubella (German measles), diphtheria, tetanus, pertussis (whooping cough), *Haemophilus influenzae* type b (Hib), and polio.

Certain individuals may also be targeted for other vaccinations, especially the influenza vaccine. This depends on your health history and your risk for getting these diseases.

Vaccination is very important for you and your children. Children usually receive most vaccines before their seventh birthday. If you didn't get vaccinated in childhood for one of these diseases, you may still be able to receive the vaccine as an adult.

What are the diseases?

Measles is a serious virus that causes a high fever, cold-like symptoms, runny eyes and a body rash. Rarely, measles can lead to pneumonia, inflammation of the brain, deafness, or mental retardation.

Mumps is a virus that causes painful swelling of the glands in the neck and behind the ears. It can lead to inflammation of the lining around the brain (meningitis) and swelling of the testicles in men. Rarely, it causes deafness or sterility.

Rubella is also called German measles. Normally, the symptoms of rubella are mild and include a rash with a low fever. However, pregnant women with rubella can have miscarriages, stillbirths or babies born with serious birth defects.

Polio is a virus that can lead to swelling of the lining around the brain (meningitis) or paralysis. It is extremely rare in the United States due to good vaccination practices. You can get polio if you are not immunized and you are exposed to infected people from other countries where polio is more common.

Diphtheria is an infection that starts in the throat and nose. It causes a thick gray covering over the back of the throat that can make breathing very difficult. This germ can also release a poison that causes paralysis and severe heart problems.

Tetanus is an infection that gets into the body when you get a serious cut, puncture wound, burn, or bite. It leads to stiffness in the muscles, especially those of the jaw ("lockjaw") and the breathing muscles.

Pertussis, or whooping cough, is a serious infection of the upper airway. It begins very much like a cold with a runny nose and cough. The cough may get worse at night, and occur in "fits" that may end in a loud whoop or vomiting. Infants are most at risk for problems including seizures, pneumonia, and brain damage from pertussis.

Continued on next page.

Hib (*Haemophilus influenzae* type b) is a bacteria that can infect the blood, the lining of the brain, and the lungs and airways. It rarely infects adults, but can be a very serious illness in infants and young children.

Pneumococcus is a bacterial infection that can cause pneumonia, blood infections, or meningitis in small children. PCV, or pneumococcal conjugate vaccine, protects against pneumococcus infection.

Hepatitis B is a virus that infects the liver. Some people with hepatitis B do not feel sick at all, but they can pass the disease on to others. The virus can lead to an inflammation of the liver, causing fatigue, nausea, lack of appetite, and a yellowing of the skin called jaundice. The inflammation can cause the liver to stop working, which is fatal.

Varicella (chickenpox) is a common viral illness in children, causing fever, cold symptoms, and a rash. Most children recover from varicella without any problems. Adults who get varicella often get serious complications from the disease, including pneumonia, encephalitis (an inflammation of the brain) or kidney failure.

What are the side effects of these vaccines?

The side effects of these vaccines are usually mild, with some redness and swelling where you get the shot and possibly a fever. Rarely, other more serious side effects can occur with any vaccine. You should talk to your health provider about any concerns you have. Health clinics can also give you information sheets on each vaccine.

What if I don't get my child vaccinated?

If you don't get your child vaccinated, they can get very sick. Also, they may not be able to enroll in a school or day-care center. Generally, state law requires all children enrolled in daycare centers, schools, and colleges to be up-to-date with immunizations (with some exemptions based on religious beliefs).

Keep your child's immunization records updated and in a safe place. You will need them as your child grows up.

Originally published in The Health Care of Homeless Persons.

Lice

What are lice?

Lice are tiny bugs that live on the human body.

There are three types of lice:

Head lice live on people's hair and make the scalp itch. The eggs often look like dandruff, but you can't pull them off your hair easily. Head lice spread when a person with head lice comes into contact with another person's hair. They can also spread when people share hats, combs and other things that touch the head or hair. Head lice are very common among children.

Body lice live on people's clothes, especially in the seams. They do not usually live on the skin. People usually find they have body lice when they get a rash from scratching. Body lice spread when you touch or come into contact with a person with body lice. They can also spread by sharing things like clothing or bed sheets that have body lice on them.

Pubic lice is most commonly spread by close body contact or sexual contact. If you have pubic lice, you should ask a doctor or nurse to exam you for other sexually transmitted diseases.

How do you get rid of lice?

For head lice and pubic lice, ask a doctor or nurse about shampoos or cream rinses that will kill lice in your hair. Usually, you have to leave the shampoo on your hair for up to 10 minutes. You then rinse your hair well and dry it with a towel. Once your hair is dry, you may have to comb any remaining eggs out of your hair with a fine-toothed comb. This takes a lot of time. Some people prefer to cut or shave their hair instead of combing.

To keep the lice from coming back, wash all linen and clothing in hot water and dry your laundry in a dryer for 30 minutes before you use it again.

If you can't wash things like stuffed animals and toys, carefully vacuum them.

Soak all your combs and brushes in the lice shampoo diluted with water. A solution of 1 part bleach to 10 parts water will also work.

For body lice, all you may have to do is take off your clothing and shower carefully. Body lice live in clothing, not on the skin. Before you put your clothing back on, you should wash your clothes in hot water and dry them in a dryer for 30 minutes. Do not put your clothing back on or sleep in the same bed after you shower until everything is clean.

If you have lice, you should see a nurse or a doctor after about a week to make sure the lice are gone. Sometimes you have to get treated again.

How can you keep from getting lice?

The best way to keep from getting lice is not to share clothing, hats, combs and other personal things. Tell people who complain about itching or rashes to see a doctor or nurse. If you have been close to a person with lice, ask a doctor or nurse to evaluate you for lice.

Originally published in The Health Care of Homeless Persons.

Scabies

What are scabies?

Scabies are tiny bugs called mites. Scabies burrow under the skin and make you itch and feel uncomfortable, especially at night. They can live anywhere on your body.

How do you get scabies?

Scabies are easy to get, especially in places where a lot of people live or play together. They spread when someone with scabies touches your skin. This can also happen when people sleep in the same bed or share clothing or bed linen. Scabies can spread from the infected person until he or she gets treated.

What do you do if you have scabies?

Scabies may be difficult to treat. A doctor or nurse practitioner or physician's assistant can give you a lotion that kills scabies.

If you have scabies:

- 1) Trim your nails so the scratching doesn't hurt your skin.
- 2) Take a shower.
- 3) Wait a few minutes for your skin to cool down.
- 4) Spread the lotion on your skin as directed.
- 5) Do not put on any other cream, ointment or body lotion.
- 6) Wait 8 to 12 hours. If you wash your hands during this time period, reapply the lotion to your hands.
- 7) Take another shower to rinse off the lotion.
- 8) Put on new or clean clothes that have been washed and dried according to the instructions below.
- 9) Wash your linen and bedclothes the morning after the treatment is finished. Everything should be washed in hot water and dried in a hot drier for 30 minutes.
- 10) You may need to repeat the treatment in 1 week – ask your doctor or nurse practitioner or physician's assistant.

For a child with scabies:

- 1) Trim the child's nails so the scratching doesn't hurt his or her skin.
- 2) Bathe or shower the child.
- 3) Wait a few minutes for the skin to cool down.
- 4) Spread the lotion on your skin as directed.
- 5) Do not put on any other cream, ointment or body lotion.
- 6) Wait 8 to 12 hours. If the child washes his or her hands during this time period, reapply the lotion to the hands.
- 7) Bathe or shower the child again to rinse off the lotion.
- 8) Put on the child new or clean clothes that have been washed and dried according to the instructions below.
- 9) Wash the linen and bedclothes the morning after the treatment is finished. Everything should be washed in hot water and dried in a hot drier for 30 minutes.
- 10) The child may need to repeat the treatment in 1 week – ask your doctor or nurse practitioner or physician's assistant.

Continued on next page.

Shelter Health:
Essentials of Care for People Living in Shelter

Vacuum anything you or your child may have touched if it can't be washed (toys, rugs, pillows).

Even after treatment, you may continue to itch for a couple of weeks. This is normal. If itching is bad, ask your doctor or nurse for a medicine to control the itch.

How do you keep from getting scabies?

Try not to share your clothing or your children's clothing and bed linen with others.

If you know someone who complains about a rash or itching, urge them to see a doctor or nurse.

If you or your children have been around someone with scabies, see a doctor or nurse.

Originally published in The Health Care of Homeless Persons.



THE FACTS OF LICE

- There are three types of human lice: *Pediculus humanus capitis* (head louse), *Pediculus humanus corporis* (body louse), and *Phthirus pubis* (pubic or crab louse).
- Bites are painless but injected saliva causes intense itching.
- Lice do not jump or fly; they are only spread through direct physical contact with a person or sharing of personal items, including clothes, bedding, combs, and hats.
- Head lice are more common in young, white females.
- Body lice are associated with low-income, poor hygiene, and overcrowded living conditions.
- Body lice are vectors for serious disease, including trench fever and endocarditis (infection of the heart valves).
- Up to one-third of people with pubic lice may have other sexually transmitted diseases.
- People with HIV/AIDS tend to have more severe infestations of scabies and be unresponsive to conventional treatment.

Excerpted from Healing Hands: Bugs That Bite February 2005

Intake, Showers, and Clean Sheets: Heading Off Infestations in Homeless Shelters

Shelter staff dealing with outbreaks of lice and scabies face some of the same barriers their clients do: misinformation, fear, and lack of resources. Education is a powerful tool that HCH clinicians provide to help shelter staff deal appropriately and respectfully with clients, prevent large-scale infestations, and protect their own health. “Staff should have communicable diseases training so they can make informed choices about their own care and the care of their clients,” Heather Barr says. As a health consultant and educator, Barr has drafted sample policies on handling lice and scabies for shelters to adopt or adapt. The key to reducing the incidence of lice and scabies in shelters is to begin with “sensitive and well-conducted intake,” Barr says. “It’s a gentle and delicate dance when you’re dealing with personal issues.”

Clients with suspected cases of lice or scabies should not be asked to leave the shelter, Barr says. “It’s more hazardous for them to remain outside.” Instead, she instructs shelter staff to let them stay for the night; if they want to stay additional nights they must bring a note from a medical provider which indicates that they have been evaluated and that treatment, if required, has been initiated. Shelter procedures on bathing and laundry vary. Some, such as Prospect House in Bridgeport, CT, require all clients to bathe and wash clothes daily. “In the year that I’ve been here, I’ve never seen a case of lice or scabies,” says Director **Patricia Ginyard**.

At Urban Ministries in Durham, NC, only those clients enrolled in the shelter’s drug or disability programs are required to wash their clothes; “overnighters” (those who use the shelter for sleeping only) are not, says **Deborah Wilson, ALPN**, with Lincoln Community Health Center Health Care for the Homeless Project. Lack of resources—from medically trained staff to bedding and laundry facilities—can make it difficult for shelters to head off outbreaks of communicable diseases. Last May, there was an outbreak of lice and scabies at People in Peril, a wet shelter in Worcester, MA. Formerly, the shelter had its own medical staff; currently the HCH Homeless Outreach and Advocacy Project (HOAP) holds clinics at the shelter twice a week, notes **Anne Lavery, MSN, RN**, Nursing Supervisor. “We talk to the staff about the need for two clean sheets, one as a barrier for the mattress and one as a barrier for the blanket,” Lavery says. “Ideally, they should clean the mattresses everyday, but realistically, this may not happen.” In January, the HOAP medical team conducted a screening for lice and scabies at the shelter. “We tried to do it in the most humane way possible,” Lavery says. “We set up screens so people had privacy. Most people were cooperative and appreciative.”

Barr’s short-hand advice for shelter staff is straightforward: Do a careful intake, intervene quickly, normalize the situation, and ensure that appropriate treatment is carried out. HCH clinicians are available as a resource to help shelters perform these tasks.

TIPS FOR SHELTER STAFF

- Ask each client about symptoms of lice or scabies at intake.
- Refer clients with symptoms for a medical evaluation.
- Wear latex gloves when examining patients suspected to have lice or scabies.
- Assist clients who need help with bathing and laundry.
- Wear disposable gowns or aprons when handling dirty laundry.

*This article was originally published in a Healing Hands issue entitled Bugs That Bite:
Helping Homeless People and Shelter Staff Cope, February 2005*

The Top 4: Asthma, Diabetes, Cardiovascular Disease, and Seizures

While there are innumerable health concerns that shelter providers might be faced with, there are some very common chronic conditions that affect large numbers of people in the housed population, and even greater percentages of people who are displaced and homeless. Four of the most common are asthma, diabetes, cardiovascular disease, and seizures. Shelter providers should equip themselves with a basic knowledge of these health problems. The following pages should help.

About Asthma

What is asthma?

Asthma is a lung disease that causes the airways in your lungs to become swollen, narrowed, or blocked. This alters the normal flow of air in and out of the lungs, which can make it difficult to breathe. Asthma affects an estimated 17.3 million people in the United States. It is the most common chronic childhood disease and a leading cause of childhood disability.

What is an asthma attack?

While experiencing an attack, a person with asthma will go through periods of worsening chest tightness, wheezing, coughing, waking at night, and/or shortness of breath. Any one or more of these symptoms can indicate an attack. Persons with asthma may have mild, moderate, or severe to life-threatening attacks of breathing difficulty if not treated properly.

Since severe attacks can be life threatening, it is important that you recognize the symptoms and properly assess the severity of those symptoms. Typically, symptom-free periods alternate with periods of acute symptoms (asthma attacks).

What are the symptoms of an asthma attack?

You may have one or all of these symptoms during an asthma attack:

- Coughing while or after exercising.
- Wheezing (a whistling noise when air passes in and out of the airway).
- Chest tightness.
- Shortness of breath.

What can trigger an asthma attack?

An “asthma trigger” is a substance that may cause an asthma attack. These substances, or allergens can be found both indoors and outdoors. Exposure to them can cause the airways in your lungs to swell, triggering any of the symptoms of an asthma attack.

Some common asthma triggers are:

Allergens:

- Animal dander (pet or animal hair, saliva, or urine).
- House dust mites.
- Cockroach droppings.
- Pollen.
- Mold or yeast spores.
- Certain common medications (check with your health care provider).
- Foods, food additives, preservatives, and colorings.

Air pollutants:

- Tobacco smoke, second hand smoke.
- Smog.
- Natural gas, kerosene or propane.
- Smoke (coal, wood burning).
- Paint fumes (sprays, strong odors).

Other:

- Viral infections in the respiratory tract.
- Exercise.
- Emotional stress/anxiety.
- Occupational exposures.
- Weather changes.

Is it possible to prevent asthma?

A substance or allergen that may cause an asthma attack can be found both indoors and outdoors. Exposure to them can cause the airways in your lungs to swell, triggering any of the symptoms of an asthma attack.

How is asthma treated?

Asthma can be diagnosed after a detailed medical history and physical examination. Your health care provider can perform a spirometry test to determine the amount of the blockage of airflow. You and your health care provider can then develop an individualized plan to help identify the correct medications, treatment, and procedures for improving your condition.

Two types of medication are used to control asthma. Quick-relief medications, such as inhalers and other anti-inflammatory drugs, provide prompt relief of the acute symptoms seen in asthma attacks. Long-term preventive care includes inhaled, injected, or oral medications that are taken daily to help prevent symptoms.

Developed by the National Alliance for Hispanic Health <http://www.hispanichealth.org/asthma.lasso>

About Diabetes

Diabetes is a disease in which the body does not produce or properly use insulin. Insulin is a hormone that is needed to convert sugar, starches and other food into energy needed for daily life. The cause of diabetes continues to be a mystery, although both genetics and environmental factors such as obesity and lack of exercise appear to play roles.

There are 20.8 million people in the United States, or 7% of the population, who have diabetes. While an estimated 14.6 million have been diagnosed with diabetes, unfortunately, 6.2 million people (or nearly one-third) are unaware that they have the disease.

Types of diabetes

There are three types of diabetes:

- **Type 1 diabetes** occurs when the pancreas no longer produces insulin. The body needs insulin to use sugar for energy. Approximately 10 per cent of people with diabetes have type 1 diabetes.
- **Type 2 diabetes** occurs when the pancreas does not produce enough insulin or when the body does not effectively use the insulin that is produced. 90 per cent of people with diabetes have type 2 diabetes.
- **Gestational diabetes** is a temporary condition that occurs during pregnancy. It affects approximately 3.5 per cent of all pregnancies and involves an increased risk of developing diabetes for both mother and child.

Is diabetes serious?

If left untreated or improperly managed, diabetes can result in a variety of complications, including:

- Heart disease
- Kidney disease
- Eye disease
- Problems with erection (impotence)
- Nerve damage

The first step in avoiding the onset of these complications is recognizing the risk factors, as well as signs and symptoms that may indicate you have diabetes. Careful management of diabetes, for those living with it, can delay or even prevent complications.

What are the risks?

Risk factors for developing diabetes include the following:

Being:

- Age 40 or older
- A member of a high-risk ethnic group (Aboriginal, Hispanic, Asian, South Asian or African descent)
- Overweight (especially if you carry most of your weight around your middle)

Having:

- A parent, brother or sister with diabetes

- Health complications that are associated with diabetes (see list on previous page under ‘Is diabetes serious?’)
- Given birth to a baby that weighed more than 4 kg (9 lb) at birth
- Had gestational diabetes (diabetes during pregnancy)
- Impaired glucose tolerance (IGT) or impaired fasting glucose (IFG)
- High blood pressure
- High cholesterol or other fats in the blood

Having been diagnosed with any of the following conditions:

- Polycystic ovary syndrome
- Acanthosis nigricans (darkened patches of skin)
- Schizophrenia

What are the symptoms?

Signs and symptoms of diabetes include the following:

- Unusual thirst
- Frequent urination
- Weight change (gain or loss)
- Extreme fatigue or lack of energy
- Blurred vision
- Frequent or recurring infections
- Cuts and bruises that are slow to heal
- Tingling or numbness in the hands or feet
- Trouble getting or maintaining an erection

It is important to recognize, however, that many people who have type 2 diabetes may display no symptoms.

How do you know if you have diabetes?

Talk with your medical provider. Early diagnosis of diabetes is extremely important. The earlier diabetes is diagnosed, the sooner steps can be taken to manage it and prevent or delay complications.

Can you prevent diabetes?

Scientists believe that lifestyle and type 2 diabetes are closely linked. This means that lifestyle is one area individuals can focus on to help prevent or delay the onset of the condition. A healthy meal plan, weight control, physical activity and stress reduction are important prevention steps.

How is diabetes treated?

Today, more than ever before, people with diabetes can expect to live active, independent and vital lives if they make a lifelong commitment to careful diabetes management.

Diabetes is managed in the following ways:

- **Education:** Diabetes education is an important first step. All people with diabetes need to learn about their condition in order to make healthy lifestyle choices and manage their diabetes.

- **Physical Activity:** Regular physical activity helps your body lower blood glucose levels, promotes weight loss, reduces stress and enhances overall fitness.
- **Nutrition:** What, when and how much you eat all play an important role in regulating how well your body manages blood glucose levels.
- **Weight Management:** Maintaining a healthy weight is especially important in the management of type 2 diabetes.
- **Medication:** Type 1 diabetes is always treated with insulin. Type 2 diabetes is managed through physical activity and meal planning and may require medications and/or insulin to assist your body in making or using insulin more effectively.
- **Lifestyle Management:** Learning to reduce stress levels in day-to-day life can help people with diabetes better manage their disease.
- **Blood Pressure:** High blood pressure can lead to eye disease, heart disease, stroke and kidney disease, so people with diabetes should try to maintain a blood pressure at or below 130/80. To do this, you may need to change your eating and physical activity habits and/or take medication.

Sources: American Diabetes Association, Canadian Diabetes Association

Responding to a Diabetic Emergency (Hypoglycemia)

The most common diabetic emergency is low blood sugar (hypoglycemia). Low blood sugar happens when the person has taken too much medication, or has taken the right amount of medication but did not eat. Low blood sugar can also happen as a result of infection or increased exertion.

Early symptoms of hypoglycemia may include: confusion, dizziness, feeling shaky, hunger, headaches, irritability, pounding heart, racing pulse, pale skin, sweating, trembling, weakness, and anxiety.

Late symptoms of hypoglycemia may include: headache, feeling irritable, poor coordination, poor concentration, numbness in mouth and tongue, passing out, nightmares or bad dreams, and coma.

What to do?

If the individual can swallow:

- Give 2 or 3 glucose tablets (available at pharmacy).
- Give 1 tube of glucose gel (available at pharmacy).
- Have the person chew 4 to 6 pieces of hard candy (not sugar-free);
- Drink ½ cup fruit juice, or 1 cup skim milk, or ½ cup soft drink (not sugar-free);
- Eat 1 tablespoon honey (place under tongue for rapid absorption into bloodstream);
- Eat 1 tablespoon table sugar, or 1 tablespoon corn syrup.

Note: *If a person has hypoglycemia and one of their diabetes medications is an alpha-glucosidase oral diabetes medicine, low blood glucose can only be treated with glucose tablets or gel.*

Sources: www.webmd.com, www.diabetes.about.com

About Cardiovascular Disease

What is cardiovascular disease?

Cardiovascular disease (which includes high blood pressure, high cholesterol, and heart disease) affects the heart by narrowing the arteries and reducing the amount of blood the heart receives, which makes the heart work harder. Cardiovascular disease is the leading cause of death across all racial and ethnic groups accounting for more than 40% of all annual deaths in the U.S.

Cardiovascular conditions often come without pain or obvious symptoms. For that reason, it often goes untreated. This can lead to even more serious health issues, including heart attack, stroke, and kidney damage. What is especially dangerous about cardiovascular disease is that you can have more than one condition at the same time without even knowing it.

Some conditions associated with cardiovascular disease include:

- **High Blood Pressure or Hypertension:** This condition often begins without symptoms. It occurs when the blood pressure against the blood vessel wall is consistently above normal.
- **Hardening of the Arteries, or Arteriosclerosis:** This disease process leads to the hardening of the arteries and occurs as we grow older. The arteries frequently “harden”, or become less flexible, making it more difficult for the blood to flow through them.
- **Clogging of the Arteries, or Atherosclerosis:** Arteries get clogged when their protective lining is damaged, allowing substances to build up inside the artery wall. This buildup is called plaque, and it is made up of cholesterol, waste materials from cells, fatty materials, and other substances.
- **Heart Attack:** A heart attack occurs when a clot blocks part or all of the blood supply that goes directly to the heart muscle. When the blood flow is cut off completely, the heart muscle begins to die.
- **Stroke:** A stroke occurs when a blood vessel that supplies blood to the brain is partially or completely blocked resulting in impairment of the brain due to reduction of the blood flow. Impairment of the brain in turn results in loss of body movements controlled by that portion of the brain.
- **Congestive Heart Failure:** This condition occurs when the volume of blood output per heartbeat is decreased due to abnormal function of the heart muscle or valve structures. The blood supply to the body tissues is not enough to meet the appropriate demand for oxygen the tissues need for biological work.
- **Peripheral Vascular Disease:** This condition occurs due to venous or arterial deficiencies in the extremities. It includes such disorders as varicose veins, phlebitis,

thrombosis, swollen ankles, cellulitis of the extremities and gangrene. This disorder is considered to be classically characteristic of the homeless condition, primarily due to people being on their feet all day, the lack of opportunities to elevate feet and legs, and often having to sleep in a sitting-up position.

What are the risk factors for cardiovascular disease?

Without a doubt, the development of cardiovascular disease is associated with some specific health-adverse behaviors. According to the Centers for Disease Control and Prevention (CDC), those behaviors are:

- **Tobacco use:** Cigarette smoking causes a build-up of plaque in the inner walls of our arteries. It is a major risk factor, and smokers have twice the chance of developing cardiovascular disease as non-smokers.
- **Lack of physical activity:** Individuals who don't engage in sufficient physical activity also have twice the chance of developing cardiovascular disease as those who are physically active. Physical inactivity can also predispose you to obesity and diabetes, both of which can also promote cardiovascular disease.
- **Eating habits:** Individuals who are overweight are at a higher risk for having high cholesterol, developing hypertension, and other chronic cardiovascular conditions than those who maintain a healthy weight. It is estimated that only 18% of women and 20% of men consume the recommended five servings of fruits and vegetables a day.

Having a family history of cardiovascular disease can also be a risk factor. Remember, a risk factor is not the cause of a disease, but it is associated with its development. In the case of cardiovascular disease, you can help reduce your risk by maintaining or adopting healthy behaviors.

How do I prevent cardiovascular disease?

Adopting healthy behaviors can significantly reduce the risk of developing cardiovascular conditions:

- Avoid any form of tobacco use and second hand smoke.
- Begin a regular program of physical activity.
- Consume healthy foods low in cholesterol and saturated fats.
- Cut down on daily salt and sodium intake.
- Maintain a healthy weight.
- Eat plenty of fruits and vegetables.

What are the signs and symptoms of cardiovascular disease?

Symptoms vary depending on the extent to which the normal flow of blood to the affected organ is interrupted. When the interruption of blood supply to the brain or heart is severe, some or all of the following symptoms can be experienced:

Heart Attack:

- Central chest pain with oppressive or squeezing feeling that lasts for few minutes.

- Chest pain that can spread to the neck, shoulders, and/or arms.
- Chest discomfort along with light-headedness, sweating, faintness, nausea, or shortness of breath.

Stroke:

- Sudden weakness of the face, arm or leg, most often on one side of the body.
- Loss of feeling in the face or body.
- Difficulty in speaking.
- Sudden loss of vision in one eye.
- Dizziness and unsteady gait.
- A sudden intense headache.

Congestive Heart Failure:

- Swelling of lower extremities called “peripheral edema”.
- Intolerance to exercise followed by shortness of breath, fatigue, and cough.

What is the treatment for cardiovascular disease?

Some conditions associated with cardiovascular disease, such as cholesterol, high blood pressure, and overweight can be managed by combining medications with healthy behaviors.

More serious conditions associated with cardiovascular disease can be life threatening. These usually require in-patient care in the hospital. Early medical or surgical treatment can reduce mortality, improve quality of life, and limit the amount of the tissue damage.

*Sources: National Alliance for Hispanic Health <http://www.hispanichealth.org/cardio.lasso>,
Balancing Act: Clinical Practices That Respond to the Needs of Homeless People
<http://aspe.hhs.gov/homeless/symposium/8-Clinical.htm>*

If Someone is Having a Heart Attack or Stroke...

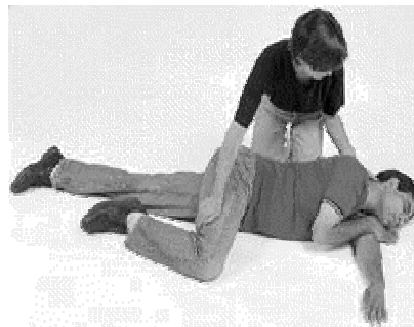
CALL 911! Heart attack and stroke are **medical emergencies** that require prompt treatment. If you suspect someone is experiencing a heart attack or stroke, **seek medical attention immediately**, even if the symptoms seem to pass quickly.

What to Do if Someone is Having a Seizure

A seizure is an abnormal movement or behavior caused by unusual electrical activity in the brain. Witnessing a seizure for the first time can be scary, especially if you do not know what to do. With some seizure types very little first aid may be needed. For example, in a partial seizure guiding someone away from danger may be all that is necessary.

DO...

- Protect the person from injury - move any sharp or hard objects.
- Guide the person away from danger if she/he is having a partial seizure.
- Cushion the person's head if they fall down.
- When the convulsive part of the seizure is at an end, place the person in the recovery position (see illustration). This will help their breathing.
- Be quietly reassuring.
- Stay with the person until she/he has regained full consciousness.
- Go over any missed events.



DO NOT...

- Try to restrain the person having the seizure.
- Put anything in the person's mouth or force anything between his/her teeth.
- Try to move the person unless she/he is in danger.
- Give the person anything to drink until they have fully regained consciousness.
- It is not usually necessary to call for an ambulance when someone has an epileptic seizure. However, it may be necessary in the following circumstances unless a medical provider can attend right away.

CALL FOR AN AMBULANCE IF...

- It is the person's first seizure, the cause of which is uncertain and needs investigation.
- Injuries have occurred during the seizure, e.g. a cut that needs stitching. The elderly are especially at risk from falls.
- The convulsive part of the seizure shows no sign of stopping after 5 minutes or 2 minutes longer than is usual for that person.
- If a second seizure occurs without the person regaining consciousness.

Adapted from Charge website <http://www.charge.org.uk/what/>

Health Promotion

It is critically important that shelters not only address health concerns such as injury and illness, but also to be aware of the need to promote good health. Particularly important are good nutrition and exercise. While it is often difficult for people in crisis to focus their energy on these matters, shelter providers can encourage and support healthy lifestyles for residents.

Additionally, we have included an article that raises the issue of oral health for people experiencing homelessness. These needs are too often overlooked by people in crisis, as well as by programs set up to shelter them. While dental care may not be the highest priority for someone fleeing natural disaster or worried about where to sleep tonight, as soon as displaced people attain some level of immediate stability, programs must be aware of acute and chronic oral health needs, and ensure that those needs are met.

Health Promotion in Shelters

Consider implementing these health education and promotion activities in your facility:

Provide practical help such as clean socks, hygiene kits, sunhats, sun block, washing facilities.

Offer classes for shelter residents on topics of interest to them. For example:

- Nutrition, healthy food choices
- Weight reduction
- Benefits of physical exercise
- Stretching, yoga
- Meditation, prayer, spiritual practices
- Stress management
- Safety measures to prevent injury
- Taking care of yourself and your children during illness
- Smoking cessation
- Others

Post health promotion signs and flyers in prominent places in the shelter. The more colorful and interesting they are, the better.

Provide printed health education materials to shelter residents.

Initiate conversations regularly with residents about their own health promotion activities, and those for their children.

Hold a “health fair” specifically targeted for homeless and disadvantaged people. Conduct the fair in the shelter if possible, or elsewhere in the community.

Develop a peer health promotion program. Provide training and support for residents to organize activities, and reach out to and counsel other residents.

Provide exercise space and equipment on the premises if possible, or access to a gym.

Provide computer access to residents to promote learning about health and wellness.

Develop a staff role focused on health education and promotion. Or develop a volunteer position for this purpose.

Inform residents about community resources regarding health education and promotion.

Be a model for healthy living as a staff member.

Homeless Family Facility Nutrition Guidelines

These guidelines can be used as a tool to assess nutrition policies and practices in a homeless facility and identify strengths as well as areas that may be improved.

1. Optimize facility and family access to food resources.

- Develop linkages with organizations and businesses in the community to improve access to food resources. Churches, restaurants, grocery stores and local businesses may be willing to assist the shelter in meeting food service needs.
- Assist families in accessing resources, such as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), the Commodity Supplemental Food Program (CSFP), Self Help And Resource Exchange (SHARE), Food Stamp Program and other government resources.
- If serving congregate meals to children 12 years of age and under, apply for meal funding under the USDA's Child and Adult Care Food Program (CACFP).
- Encourage and assist parents to enroll their children in School Breakfast, School Lunch and summer food programs. Additionally, shelters can apply to be a summer meal site.
- Provide on-site and referral resources for emergency formula, food and special diet needs.
- Allow residents to retain food stamps and either WIC or CSFP vouchers for individual use to aid in meeting nutritional needs. Allow families to accrue these resources to establish a family food pantry which will aid in the transition to permanent housing.

2. If families are completely or partially responsible for their own meals, provide adequate resources for preparation of meals and snacks.

- Provide families with appropriate private cooking and refrigeration facilities.
- If only shared cooking and refrigeration facilities can be provided, develop policies and practices to deal with resulting issues, including adequate space, cleaning, security of stored foods and child safety in shared kitchen spaces.
- Assess a family's need for nutrition assistance and provide a starter-set of food items at the time of entrance into the facility, if indicated.
- Assess a family's need for food preparation equipment such as pots, pans and cooking utensils and provide a starter set, if indicated.
- Assess and address a family's need for nutrition education, including healthy recipes, budgeting, meal planning and food safety.
- Assess the food shopping opportunities in the shelter's direct environment and, if indicated, arrange transportation to markets with nutritious and economical food selections.
- Promote food safety by providing families with education and necessary items such as dishwashing detergent, dishtowels and hand soap.

3. If the facility provides meals and/or snacks, plan menus that are appetizing, nutritious, ethnically appropriate and child-friendly.

- Ensure that meals include choices from all food groups in the USDA food guide pyramid.

Continued on next page.

- Make an effort to limit offerings of high calorie, high fat and low nutrient-density foods such as cakes, cookies, chips and doughnuts. Provide more nutritious foods, such as fresh fruits and vegetables and yogurt.
- If serving specific ethnic or religious groups, try to include some ethnic menus and menu items to accommodate varying preferences and religious practices.
- Plan the menu in accordance with needs and tastes of children. Offer alternatives for foods which are not safe or suitable for younger children. Provide child-sized eating utensils and arrange for appropriate child seating.
- If serving food cafeteria-style, try to accommodate individual requests for smaller portion sizes and allow individuals to decline certain items, especially for children and adults with poor appetite.
- Provide a forum for families to give menu suggestions and feedback regarding all aspects of food provision.
- Although families can assist in meal preparation and planning, having a professional cook is the most efficient way to ensure that meals are consistent in quality and food resources are used most economically. A professional cooking staff may also serve as a resource for training and education of residents and other staff members.
- If employing foodservice staff, periodically assess food safety procedures and the need for additional training. Provide foodservice staff with training opportunities when indicated (i.e., at local community colleges, area restaurants or via the Internet).
- Document and investigate facility food preparation and handling whenever vomiting and diarrhea, which are often symptoms of food-borne illnesses, occur among residents.

4. Identify common nutrition needs and develop policies and practices to meet those needs.

- Identify and screen for frequently occurring special nutrition needs in the population served. Special needs include those due to medical conditions such as underweight, diabetes, lactose intolerance and food allergies, temporary illnesses such as influenza, diarrhea and vomiting. These needs also include non-medical choices such as vegetarian diets or abstinence from certain foods due to religious beliefs.
- Provide food and beverages which accommodate special needs, or help families to access them. Develop a plan to meet the identified needs of specific families, including nutrition education and referral of those with nutrition problems to a healthcare provider and/or nutritionist.
- Try to accommodate the medical provider or nutritionist's recommendations related to nutrition; this applies to facility practices and procedures as well as individual needs.
- Help pregnant and breastfeeding women meet increased nutritional needs by providing extra meals and snacks as well as a prenatal vitamin supplement. If this is not possible, assist pregnant and breastfeeding women in obtaining and storing these resources.
- Children need two or three healthy snacks in between meals to meet their nutritional needs. If snacks are not provided by the facility, families need access to refrigeration and food storage to allow them to meet this need.
- Encourage new mothers to breastfeed. Successful breastfeeding may be promoted by providing a quiet area for feeding, a supportive environment, access to a lactation consultant and a clean, safe place to refrigerate and/or freeze pumped breast milk.

Continued on next page.

- Assist mothers with formula feeding infants to provide adequate nutrition by allowing 24 hour flexible access to formula preparation, storage and sanitation. Ensure a sufficient quantity of formula by helping families to access WIC and providing emergency formula when necessary. A supply of emergency formula may be obtained through pediatricians' offices, the local food bank, or formula company sales representatives.
- Help families transition older infants to table food by providing or helping them provide appropriate foods of the right type and texture.
- Train shelter staff in nutrition and the specific nutrition needs of the population served.

5. Adopt facility regulations and services that improve nutrition status.

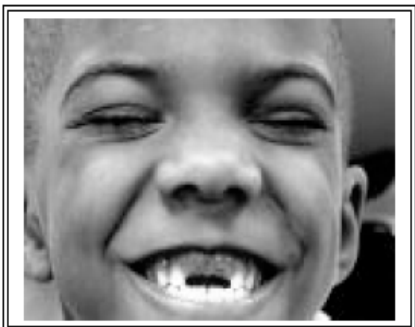
- Provide refrigeration and food storage in the family's room, so families can have better access to food and formula. Pest control and hygiene can be achieved by education, periodic inspections and regular use of a pest control service.
- Provide access to drinking water, especially during the summer months.
- Allow families to stay in their room during the day, or in a communal room in the facility, so they are able to feed children regular meals and snacks.
- If families are not allowed to remain in the facility during the day, at a minimum make arrangements with other facilities to provide shelter, meals and snacks during that time period or supply families with a non-perishable food package for the day.
- If families are not allowed to remain in the facility during the day, make exceptions for families with young children or certain medical conditions and in extreme weather.

6. Food provides more than nutrients - let food and meals help to improve the living environment.

- If serving meals, try to create a pleasant, organized and calm eating environment. Using family-size tables to provide privacy at meal times can help children adjust to a new environment and improve food intake.
- If not serving meals routinely, organizing a regular group meal for families can help create a sense of community and provide an opportunity for education on a range of nutrition and non-nutrition topics.
- Ensuring appropriate nutrition in a less favorable environment requires substantial parenting skills and emotional strength from the parent. Parental frustration and depression can have an adverse effect on dietary intake of child and parent. To support the feeding relationship, provide a nurturing environment for the parent and child, with access to family support and counseling services.
- Partner with a local restaurant, chef or culinary school which may provide culinary training, a fundraiser and/or a festive event in the shelter. Community colleges with food service or nutrition courses may also be a valuable resource.

The Children's Health Fund <http://www.childrenshealthfund.org/publications/pubs/nutritionguidelines.pdf>

Why Dental Care Matters to Homeless People



Tooth pain is the number one reason for hospital emergency room visits, reports **Judith Allen, DMD**, Clinical Director of the McMicken Dental Center for the Homeless in Cincinnati, Ohio. Most ERs just dispense pain pills and tell patients to find a dentist elsewhere, she says. Limited access to free or low-cost dental care forces many homeless people to fend for themselves. Some get desperate and try to remove their own teeth, leaving root tips that eventually abscess and increase their pain, says Allen.

Dental pain can be excruciating. It interrupts sleep, makes people irritable, and interferes with regular attendance and performance at work or school. Homeless children, who experience higher levels of dental disease than other children, often do poorly in school for this reason, says Allen. “People with rotten or missing teeth look unhealthy, uneducated, unintelligent, and unreliable to employers.” They often have trouble eating and avoid social interactions, exacerbating the isolation of homelessness.

MORE ADVANCED DISEASE Far more serious dental and oral health problems are seen in homeless than in stably housed patients, according to HCH providers. Among the most common problems seen in homeless clients are profound dental decay requiring extractions or root canals, periodontal (gum) disease, missing teeth, and dental problems associated with medical conditions, according to **Amalia Torrez, CDA**, manager of the HCH dental clinic in Albuquerque, New Mexico.

Rampant dental caries “It is not unusual to see young homeless people in their 20’s who require extraction of all 28–32 teeth,” observes Dr. Allen. Use of alcohol (one of the early dental anesthetics) and illicit drugs such as cocaine is common among homeless youth. These drugs dull the perception of pain and interfere with nutrition. Drug users often crave sugar, which suppresses their appetite for more nourishing food and creates an acidic environment in which the micro-organisms contained in dental plaque thrive. They feed on teeth and gums, causing chronic oral infection, dental caries, and periodontal disease.

When a tooth is decayed at the gumline, the nerve gets infected and root canal therapy is required to salvage the tooth, explains Allen. “Gumline caries are the most devastating because they are least fixable. Without treatment, oral infection can advance to brain abscesses and Ludwig’s angina, with life-threatening consequences.” Regular dental cleaning and checkups, the main ways to prevent these pathologies, are not available to many homeless people.

Periodontal disease is the leading cause of tooth loss, and may also play an important role in heart and lung disease, stroke, low birthweight and premature births. Periodontal disease is exacerbated by smoking, and over two-thirds of homeless people smoke.

“We see ourselves, and others see us, in terms of the face we present to the world. Diminish that image in any way and we risk the loss of self-esteem and well-being.”

*Oral Health in America:
A Report of the Surgeon General, 2000*

Continued on next page.

Oral cancer Heavy use of tobacco by homeless people also increases their risk for oral cancer. Use of smokeless tobacco is particularly toxic. Left in the mouth for hours at a time, “dips” contain additives (slate, sand) that exacerbate cell changes in the mouth.

TRAUMA Damaged teeth secondary to assault are frequently seen in homeless people. “One woman who slept in doorways was kicked by kids while she slept, resulting in a fractured jaw,” recalls Allen. “When the swelling didn’t subside after three weeks, she went to a city clinic, where she was told she had an abscess, given antibiotics, and told to come back, but did not return. Unable to eat, she finally came to the HCH clinic, where providers found a fractured jaw and maggots living in her cheek. She required extraction of a tooth and hospitalization to clean out the wound and stabilize her fracture.”

COMORBIDITIES Diabetes and HIV/AIDS are among the chronic conditions frequently seen in homeless patients that exacerbate oral disease. People with diabetes don’t heal well and are three times more likely to have periodontal disease than persons with normal blood sugar levels, reports Allen. Immunocompromised patients with AIDS or those receiving chemotherapy frequently have opportunistic infections such as oral candidiasis (“thrush”).

Certain medications can exacerbate existing dental disease, adds Torrez. For example, Dilantin (phenytoin), used to treat seizure disorders, can cause gingival hyperplasia, an overgrowth of the gum that can cause early periodontal disease. Other medications cause dry mouth, reducing the flow of saliva, which protects teeth against decay-causing bacteria.

SELF-ESTEEM Eliminating dental disease in homeless persons often involves getting rid of their teeth,” says Allen. “But promoting oral health and well-being involves much more than eliminating disease.” Medical providers should consider the effects of dental problems on how people present to others, she advises. “When you fix someone’s smile, you enhance their self-esteem.”

Amalia Torrez recalls a homeless patient with heart and lung problems who came to the HCH clinic for smoking cessation services. “Toothless except for a couple of broken teeth in his lower jaw, he initially responded to questions in a gruff manner and seemed extremely embarrassed and self-conscious. When asked what would most improve his life, he answered, ‘Dentures.’ Getting dentures dramatically improved his self-confidence and attitude toward his health. He has since cut down on smoking, communicates easily with others, and can eat nuts, the food he missed most when he didn’t have teeth.”

Shelter Health:
Essentials of Care for People Living in Shelter

Environmental Health and Safety

Learning Goal:

- To determine ways to create shelter environments that are safe and healthy for residents and staff.

Shelters are often designed with one fundamental goal in mind: give people a safe place to be to prevent them from dying on the streets. As shelter stays have become longer, due to lack of affordable housing or the magnitude of natural disasters, it has become ever more critical that shelters minimize the risk of infection, provide safe and adequate food and water, and ensure basic health and hygiene.

In addition to these environmental health concerns, the possibility of violence is inevitably heightened as people are living in tight quarters under immense stress. Shelter providers must constantly be aware and work to prevent family violence, child abuse, rape, and the possibility of staff and volunteers being attacked. When violence does occur, staff should be equipped to deescalate violent situations and provide support for residents who have been victims of violence.

This segment of the guide will emphasize safe environmental health practices that will minimize the spread of disease. Additionally, we will take a broader look at steps shelters can take to prevent violence in congregate living settings.

The Tool Kits

At the beginning of each section of this Guide, readers will find lists that outline the contents of the Tool Kits that can be found in electronic form on the CD that accompanies this Guide. While some of the tools and handouts are found both in the Guide and in the Tool Kits, most of the items listed below are only found in the Tool Kits. They are to be used to supplement the material in the Guide and to provide shelter providers with day-to-day tools for use in the shelters.

Tool Kit C: Environmental Health and Safety

- C-1 Hand Washing Flyer
- C-2 Food Prep brochure on food-borne bacteria
- C-3 Food Prep—Chill
- C-4 Food Prep—Clean
- C-5 Food Prep—Cook
- C-6 Food Prep—Separate
- C-7 “Healthy Shelter Living”
- C-8 Standard Precautions Policy
- C-9 Fluid Clean-up Policy
- C-10 Fluid Exposure Policy
- C-11 Laundry Hygiene Policy
- C-12 Infection Prevention and Control Manual for Homeless and Housing Service Providers
- C-13 Shelter Health and Safety Best Practice Guidelines
- C-14 Health and Safety Evaluation Form for Homeless Service Agencies
- C-15 Tuberculosis Prevention and Control Guidelines for Homeless Service Agencies
- C-16 TB in Homeless Shelters: Reducing the Risk
- C-17 Wasatch HHC Program Safety Manual
- C-18 “For the Women of Katrina: Protection from Violence against Women and Children”
- C-19 “Violence and Disasters”
- C-20 “Preventing Violence after a Natural Disaster”
- C-21 Animals in Shelters
- C-22 First Aid Kit Supplies

COMMUNICABLE DISEASE CONTROL HAND WASHING

General Information:

- Hand washing is the single most effective and least costly way to reduce the spread of infections, including the common cold, hepatitis A, food borne illnesses, and many other viral and bacterial diseases.
- Alcohol-based hand rub is also effective in limiting the spread of such diseases.
- Shelter and other environments should encourage and support good hand hygiene.

Facility Recommendations & Environmental Modifications:

Ensure that your shelter or facility has:

- Posters encouraging *frequent* hand washing posted in common areas.
- Posters showing proper hand washing *techniques* posted by all sinks.
- Sinks and hand washing facilities that are easily accessible to staff and clients.
- Sinks that are kept in good repair, drain properly, and have both hot and cold water.
- Soap dispensers that contain soap and are in good working order. Non-refillable soap dispensers are recommended.
- Disposable towels available.
- Facial tissues such as Kleenex available for staff and clients. Tissues help contain sneezes and coughs and provide a barrier for hands. Trash cans should be available for proper disposal of tissues.
- Alcohol-based hand rub dispensers installed at entry areas.

Staff Recommendations:

Staff should:

- Model and encourage good hand hygiene.
- Wash their hands immediately after using the toilet.
- Wash their hands before serving, preparing or eating food.
- Wash their hands before and after providing any “hands on” assistance to clients (such as assisting with mobility, balance, health or hygiene needs).
- Wash their hands after handling clients’ unwashed clothing or bedding.
- Wear aprons/coveralls and gloves when handling soiled laundry to reduce risk of infection.
- Wear gloves when handling client belongings to reduce risk of infection from bacteria, viruses, lice or mites, and to reduce risk of infection by needle stick.

Procedural Recommendations:

- Encourage staff and clients to wash or sanitize hands upon entering the shelter. This will effectively reduce the number of germs entering the shelter. Alcohol-based hand rub dispensers installed at entry areas encourage this practice.
- Do NOT use cloth towels or re-use paper towels.
- Instruct clients and volunteers who serve or prepare food to wash their hands ahead of time.
- Ensure that your shelter has a policy regarding blood borne pathogens control.

*Recommended Shelter Health and Safety Best Practice Guidelines – July 2005
Developed by Health Care for the Homeless, Public Health – Seattle & King County*

Guidelines for Environmental Safety in Shelter

Universal Precautions

- Communicable disease control measures in place.
- Information on universal precautions and proper hand washing procedures is posted.

Emergency Procedures

- Staff trained in CPR, first aid and emergency procedures.
- CPR and Heimlich maneuver procedures are posted.
- Staff trained in evacuation procedures for an emergency. Procedures are posted and reviewed with clients.
- Phone is available 24 hours a day for emergencies.
- List of emergency phone numbers is posted by phones.
- Emergency equipment kept in working condition and monitored regularly.

Facility Safety

- Regular walk through of building to identify hazards.
- Adequately marked exits that are open.
- Furniture and toys are cleanable, durable and safe.
- Safe and adequate heat with regular checks by the fuel company.
- Adequate ventilation and screens.
- Adequate waste disposal containers.
- Building is insect and rodent free.
- Plumbing is in working order (hot and cold water, toilets flush, sink drains).
- Facility is accessible to people with disabilities.
- No illegal drugs, alcohol or weapons allowed.

Fire Safety

- Fire drills conducted on a regular basis.
- Smoke detectors and fire extinguishers in place with regular servicing checks.
- Smoking is not permitted, or is limited to specific areas.

Homeless Health Care Los Angeles

Guidelines for the Control of Communicable Disease in Shelter

Health Care Prevention Measures

Do a health assessment on each client upon arrival at the shelter. Ask about communicable disease symptoms. Refer those who are sick to a doctor or clinic as soon as possible.

Maintain a daily census listing all staff, volunteers, and clients who are in the facility. This serves both security and infection control purposes. For example, if a person with a case of active TB is found to have stayed at the shelter, a daily census allows health department officials to know who was at the site when and to determine who may have been exposed.

Avoid overcrowding. Provide good ventilation and circulation of air, especially in sleeping areas.

Isolate those who are sick, preferably in a private room if possible.

Educate staff on ways to prevent the spread of disease, especially hand washing. Always wash your hands:

- After using the bathroom
- After cleaning up blood, feces, urine or vomit
- Before preparing food
- After diapering a child

Make sure all children are up-to-date on immunizations. (*Do you know which ones are required and when?*)

Know your public health nurse and call her if you suspect contagious disease in your shelter.

Restrooms

Each restroom should have:

- liquid soap dispensers
- toilet paper (in all dispensers)
- paper towels
- lined trash can
- lined sanitary napkin/tampon disposal can in restrooms used by women
- self-closing door in each stall
- screened windows
- vents
- cleanable floors, walls and ceiling

Provide a separate diaper changing area:

- wipe off changing area each time with solution prepared fresh daily (1 tablespoon of bleach in 1 quart of water in a labeled spray bottle)
- insist on hand washing after diapering a child

- insist that dirty diapers be disposed of in specified places only – use a lined trash can with a tight-fitting lid and empty frequently

Cleaning

Clean mattresses and pillows with an appropriate cleaning solution between clients.

Wash linens and towels in hot (140 degree) water.

Use separate cleaning items for the bathrooms and kitchen.

Store cleaning items in a cabinet or storeroom away from the kitchen.

Use disposable latex gloves (not rubber gloves) when cleaning, particularly when:

- cleaning up blood, feces, urine or vomit
- caring for any person who is bleeding, vomiting or cannot control their bowels or urine
- touching any clothes, towels or sheets that are bloody or have feces, urine or vomit on them

Follow these steps when cleaning up spills of blood, feces, urine or vomit:

1. put on latex gloves
2. clean up area with paper towels or newspapers
3. place paper towels or newspapers in trash can with plastic liner
4. spray area with bleach mix: 1 part household bleach to 10 parts water mixed fresh daily in labeled spray bottle
5. let bleach sit 10 minutes before wiping it up
6. wipe up bleach with paper towels
7. throw out towels in plastic lined trash can
8. remove gloves by the base of the glove
9. throw away gloves in plastic lined trash can
10. tie plastic liner and dispose in trash dump for pick up
11. wash your hands

Keep the area as clean as possible. Bathroom and shelter areas can be cleaned with regular soap and water and can be disinfected with bleach mix if needed. Sponges or rags used to clean the floor or any body fluid should not be used to wash dishes or clean food preparation areas.

Clients' Personal Items

Separate clients' personal items (clothing, pillows, sheets, towels).

Strongly discourage sharing of personal items (razors, toothbrush, hairbrush, comb, etc.)

Adapted from Homeless Health Care Los Angeles Guidelines

Standard Precautions in Shelters: Cleaning Up Blood/Bodily Fluids

- 1) Put on **protective gear**. If it is possible that blood or bodily fluids may spray or splatter, wear **protective eye covering (plastic goggles)**. Put on **latex gloves**. If there is a possibility that your clothing may become soiled, put on a **protective gown** (as when handling laundry or soiled clothing). Keep the scene clear of people.
- 2) Get a **bucket or spray bottle, bleach, and paper towels or a mop** to clean the floor and other areas. If the area is large, put $\frac{1}{4}$ cup **bleach** in a gallon of **cool water** (hot water destroys the bleach). Spray the area with this solution. If the area to be cleaned is small, you can make a solution of bleach and cool water in a **quart spray bottle**. Use 1 teaspoon of bleach per quart. This bleach solution must be discarded after 24 hours. It is recommended that a fresh solution be mixed up every time it is needed.
- 3) Blot up as much of the spill and the bleach solution as possible with **paper towels**. If there is a large volume spills or vomit, use **kitty litter** to absorb. Dispose of these materials in a **plastic garbage bag**.
- 4) If you used a **mop**, rinse the mop in **bleach solution** and allow to dry. Dump the leftover solution down the drain or toilet. **DO NOT** use a sink that is normally used for food preparation.
- 5) Pick up any soiled debris (clothing, bedding, towels, or bandages) and place in a **garbage bag**. If you are finished cleaning, remove your protective gear and gloves and put them in the garbage bag. Tie off the garbage bag and place it in the regular trash. Only very large spills need to be placed in special biohazard bags and disposed of by an approved facility.
- 6) Wash your hands thoroughly. Re-stock the **clean-up kit**. If you have had significant exposure to bodily fluid (needle stick or contact with mucous membrane or non-intact skin) contact a supervisor **immediately**.

Developed by Health Care for the Homeless Network, Public Health – Seattle & King County, WA

Sample Shelter Policies

Shelters that have been in existence for many years have often developed sophisticated policies and procedures to address environmental health issues. New shelters, though, particularly those created quickly in response to a natural disaster, have not had the time to develop policies to address every eventuality. Here we offer a number of samples intended to guide shelters in developing their own environmental health policies.

These were developed by Health Care for the Homeless Network, Public Health – Seattle & King County, Washington. An entire set of recommended shelter guidelines can be found in the *General Information Tool Kit* on the CD that accompanies this Guide.

Sample Policy: Standard Precautions in the Shelter Setting

TITLE: Standard Precautions as it Relates to Infection Control

SCOPE: Homeless shelter staff and volunteers who may possibly face contact with bodily fluids or other potentially infectious materials as a result of performing their job duties

PURPOSE: To provide guidelines to agency management, staff, and volunteers regarding the use of Standard Precautions to minimize the risk of employees and volunteers coming in contact with bodily fluids which may contain blood-borne pathogens as well as other infectious agents

RESPONSIBILITIES

Agencies shall:

1. Provide opportunity for the staff to be trained in the control of infectious diseases (including blood borne pathogens) as it pertains to the shelter setting. Agencies may contact Health Care for the Homeless at (206) 296-5091 to arrange training free of charge.
2. Make every attempt to achieve levels of practice as outlined in the Basic Shelter Health and Safety Standards, Staff Health Policy, and other applicable Health and Safety Policies recommended by Public Health - Seattle & King County.
3. Provide all equipment needed to achieve appropriate hand washing (**hot and cold running water, soap, paper towels**). This equipment should be accessible to employees at all times.
4. Provide employees with reasonable access to **personal protective apparel** such as **latex gloves (nitrile gloves must be made available in all situations for employees with sensitivity to latex), goggles, protective gowns, and CPR shields**.
5. Have a plan in place for post-exposure to potentially infectious materials and employees will be trained in its use.
6. Outline basic procedures for all employee duties that may involve contact with bodily fluids or other potentially infectious materials. Such duties include but are not limited to: providing assistance with personal hygiene, handling soiled laundry, providing assistance to a sick client, providing first aid, providing CPR, and cleaning up after spillage of bodily fluids. In all such cases the agency will mandate a Standard Precautions approach, which is simply an infection control approach that treats all body fluids as potentially infectious. The agency may consult with a Health Care for the Homeless Public Health Nurse for assistance with outlining these duties (206) 296-5091.

Employees shall:

1. Agree to follow the procedures regarding duties which may involve contact with bodily fluids and other potentially infectious materials.
2. Immediately report any significant exposure incident to the supervisor. Contact of the employee's non-intact skin (chapped, cracked, scratched or otherwise open), eye, or mucous membrane with blood or other potentially infectious material is a significant exposure.

Continued on next page.

DUTIES WHICH MAY EXPOSE EMPLOYEES IN THE SHELTER SETTING TO POTENTIALLY INFECTIOUS MATERIALS

First Aid and CPR:

Employees who are trained in First Aid and CPR may elect to assist clients needing these interventions. The agency should provide equipment to reduce the risk of infection while rendering such aid. Equipment that should be available and accessible to the employees includes:

- Latex gloves
- CPR masks
- disposable or cotton gowns that tie in the back
- safety goggles
- clean-up materials*

Assessment of wounds, skin conditions, scalp or hair problems:

Clients may ask staff to examine wounds, cuts, burns, injuries, skin conditions, or to check for the presence of lice or scabies. Staff should don latex gloves when asked to do any type of examination beyond visual. The agency should make latex gloves available for such occasions.

Assisting with personal hygiene or toileting:

Clients may request assistance by staff with hygiene (dental care, care of dentures or oral prostheses, assistance with bathing or cleaning up after a bowel movement or urination, changing diapers, cleaning up spill of menstrual fluid, assistance with removal of head lice or lice eggs, etc.) The agency should supply latex gloves for such purposes, and staff should be able to use gowns if they feel they need greater protection. Diaper changing areas should be equipped with a lined trash can, spray bottle of bleach solution, protective covering (such as old computer paper), paper towels, and gloves.

Assisting a sick client:

Clients who are vomiting, drooling, sweating profusely, or being incontinent of stool or urine may request assistance with cleaning up or changing clothes. The agency should provide latex gloves, reusable or disposable gowns and appropriate supplies for cleaning the environment as needed (mop, bleach, bucket, paper towels, etc.)

Assisting Clients Who Have Soiled Bedding or Laundry:

Refer to the sample policy on “Laundry” for details. As much as possible, have the client handle their own clothing and bedding. Wear gloves and a gown when handling soiled laundry. Encourage the client to discard any heavily soiled laundry. Heavily soiled linens should also be discarded or laundered separately and bleached.

* For information on supplies for cleaning the environment after contamination with bodily fluids (including vomit, excrement, urine, blood, saliva, mucous) please refer to the sample policy on “Blood/Bodily Fluids Clean-up Protocol”

Developed by Health Care for the Homeless Network, Public Health – Seattle & King County, WA

Sample Policy: Blood/Bodily Fluids Clean-Up in the Shelter Setting

When you provide First Aid or when you clean an area or handle any items soiled with blood or bodily fluids (urine, vomit, blood, feces, semen) please take precautions to protect yourself and others from infection. Always follow these simple steps when you clean up after blood/body fluids spills:

Equipment:

- Paper towels
- Plastic garbage bags
- Kitty litter (for big spills)
- Disinfectant (bleach 1:10 dilution)
- Mop & mop bucket
- Spray bottle

Protective apparel:

- Latex gloves
- Eye/face protection (plastic goggles)
- Protective gowns or aprons

Policy/Procedures:

Spill clean-up materials are located _____ along with a copy of this document.

- 1) Put on **protective gear**. If it is possible that blood or bodily fluids may spray or splatter, wear **protective eye covering (plastic goggles)**. Put on **latex gloves**. If there is a possibility that your clothing may become soiled, put on a **protective gown** (as when handling laundry or soiled clothing). Keep the scene clear of people.
- 2) Get a **bucket or spray bottle, bleach, and paper towels or a mop** to clean the floor and other areas. If the area is large, put $\frac{1}{4}$ cup **bleach** in a gallon of **cool water** (hot water destroys the bleach). Spray the area with this solution. If the area to be cleaned is small, you can make a solution of bleach and cool water in a **quart spray bottle**. Use 1 teaspoon of bleach per quart. This bleach solution must be discarded after 24 hours. It is recommended that a fresh solution be mixed up every time it is needed.
- 3) Blot up as much of the spill and the bleach solution as possible with **paper towels**. If there is a large volume spills or vomit, use **kitty litter** to absorb. Dispose of these materials in a **plastic garbage bag**.
- 4) If you used a **mop**, rinse the mop in **bleach solution** and allow to dry. Dump the leftover solution down the drain or toilet. **DO NOT** use a sink that is normally used for food preparation.
- 5) Pick up any soiled debris (clothing, bedding, towels, or bandages) and place in a **garbage bag**. If you are finished cleaning, remove your protective gear and gloves and put them in the garbage bag. Tie off the garbage bag and place it in the regular trash. Only very

Shelter Health:
Essentials of Care for People Living in Shelter

large spills need to be placed in special biohazard bags and disposed of by an approved facility.

- 6) Wash your hands thoroughly. Re-stock the **clean-up kit**. If you have had significant exposure to bodily fluid (needle stick or contact with mucous membrane or non-intact skin) contact a supervisor **immediately** and follow the sample policy for “blood/bodily fluid exposure”.

Developed by Health Care for the Homeless Network, Public Health – Seattle & King County, WA

Sample Policy: Blood/Bodily Fluid Exposure

The following information should be provided to the employee's health care provider or the Emergency Room MD immediately after any incident of significant body fluid exposure by needle stick or contact with mucous membrane or non-intact skin.

- Date and time of exposure:**

- What job duty was the employee performing at the time of exposure?**

- What sort of bodily fluid was the employee exposed to?**

- How much of the fluid did the employee come in contact with?**

- What part of the employee's body was exposed to the fluid?**

- How long did the employee remain in contact with the bodily fluid?**

- Did the employee have any breaks in the portion of their skin that contacted the bodily fluid?**

- In the case of a needle stick or other sharp object injury, how deeply did the needle or object penetrate, and was fluid injected into the employee?**

- Was the source material known to contain HIV or hepatitis B or C? (the source can be asked to voluntarily provide this information, and to volunteer to be tested for these conditions)**

Developed by Health Care for the Homeless Network, Public Health – Seattle & King County, WA

Sample Policy: Laundry Hygiene in the Shelter Setting

TITLE: Laundry Procedures as it Relates to Infection Control

SCOPE: Shelter staff, volunteers, and clients

PURPOSE: To provide guidelines to staff, volunteers and residents who handle linens and laundry in a safe and effective manner to reduce the risk of spread of infectious diseases

BACKGROUND INFORMATION:

For the purpose of this policy, all linens and personal laundry of clients should be considered contaminated and should be treated carefully to avoid spread of infectious disease. Scabies, lice, and other bacterial pathogens (staphylococcal and streptococcal bacteria) are difficult or impossible to see. Laundry should be handled as little as possible. If possible, clients should handle their own laundry.

POLICY/PROCEDURE:

I. General Practices

- Staff should wear **gloves** when in contact with any used or worn laundry items, whether obvious contamination is visible or not.
- **Gowns or aprons** should be worn whenever it is likely that a staff person's clothing could come in contact with laundry.

II. Laundry Washed by Shelter Staff on Premises

- Use a hot wash cycle (at least 105-110 F for 10 minutes) followed by thorough drying in a hot dryer (160 F). This process is sufficient to decontaminate laundry. No other additives such as bleach are necessary to sanitize laundry, unless stain removal is desired.
- Any kitchen laundry or other items used by staff (towels, aprons, etc) should be washed and dried in the above manner.
- Staff/agency laundry should be washed in batches separate from client bedding and clothing.
- If linens are heavily soiled with feces, large amounts of solid material should be disposed of in a toilet. Handling of feces should be avoided whenever possible. If rinsing is required, staff should take care to minimize handling and avoid splashing.
- If possible clients should be asked to rinse their own linens when they are soiled.
- Wet linens should be stored in a **plastic bag** while awaiting final wash to avoid any leaking and reduce odor.
- Dispose of linens if soiling is severe.

III. Laundry Supplied by a Laundry Service

- Linen awaiting pick up by a laundry service should be stored in a contained bin or bag so that laundry cannot come in contact with clients, staff, the floor, or other clean items.
- Wet bedding should be placed in a plastic bag inside the bin so that leaking cannot occur.

Continued on next page.

Shelter Health:
Essentials of Care for People Living in Shelter

- Only large amounts of feces that can be easily removed should be disposed of in the toilet. No further rinsing or handling should be done by shelter staff.

IV. Bedding Stored for Returning Clients

- Used linen may not be transferred to a different client.
- Used bedding should be stored such that the bedding of different clients is not touching it. This will prevent cross contamination.

V. Supplies and Equipment

- Shelters should maintain washers and dryers in good working order or should contract with a Laundry Service for routine delivery and pick-up.
- If laundry is done on site, the water temperatures should be at least 105-110 F.
- Shelters should supply gloves, gowns or aprons, laundry detergent, plastic bags, and plastic laundry baskets or laundry bins.

Developed by Health Care for the Homeless Network, Public Health – Seattle & King County, WA

Environmental Health is Not Just About Control of Disease

In addition to following clear guidelines on cleaning, washing, food handling, and fire safety, shelters should think very broadly about what it means to create a truly “safe environment.” This means not only de-escalating violence when it happens, but also working to minimize the risk of violence in the first place. It means creating spaces and policies that decrease the likelihood of physical and sexual abuse, rape, and theft.

While this guide cannot offer all the advice necessary to accomplish such a task, we offer here several pieces, including a safety manual that was developed by Wasatch Homeless Health Care (Salt Lake City, Utah) to help staff deal with potentially volatile situations.

The material below also draws attention to groups particularly vulnerable to violence – women, children, and sexual minorities.

Wasatch Homeless Health Care Program Safety Manual

Purpose

The purpose of this manual is to outline proper procedures for handling situations with aggressive patients that have the potential to further escalate into violence. Staff safety is our top priority at all times. It is also important to respond to aggressive or violent situations in a professional and sensitive manner. Our patients are individuals who deal with grave physical and emotional difficulties daily, and they should not be subjected to unnecessary suffering from interacting with clinic staff or volunteers.

Patient Stress and Special Extenuating Circumstances

When serving our patients, it is important to keep in mind the extremely adverse living conditions and backgrounds patients come from. Stressful living situations break down morale and social behaviors such as courtesy and patience. Under these circumstances, it can be challenging to deal with such a person. If the patient is involved with drugs or alcohol, suffers from a mental illness, or has a serious antisocial background such as a history of criminal activity or prison, it can be especially difficult.

Another factor exacerbating patients' frustration is the fact that many of them frequently interact with a multitude of private and public agencies to get basic needs met. Consequently, during the process of waiting, answering personal questions and applying for various types of assistance, their frustration level often becomes elevated. By the time that they visit our clinic, they may be – understandably – in the mood to react negatively towards our requests or instructions.

Although a patient's negative behavior may appear unwarranted, this behavior may be a learned survival technique. Through hard living, some patients have found that an aggressive, demanding behavior will get their needs met no matter how inappropriate.

In addition, there are individuals who blame the system for everything that has happened to them. These patients give up very easily using passive-aggressive behaviors – such as walking out – to express frustration. It is important to remember not to take a patient's negative or aggressive behavior personally. There are reasons for this behavior, and most likely you are not the reason.

Regardless of the patient's actions, it is imperative that staff reactions not encourage further negative behaviors or responses. Instead, we can employ simple intervention strategies when a patient begins to act inappropriately within the clinic environment.

Guidelines for Addressing Aggressive Patients

Strategies for dealing with aggressive individuals are best formulated around the principle of least restrictive measure. This means starting with the least invasive tactic for subduing the aggressor and not advancing to the next level of restriction unless absolutely necessary.

The three levels of intervention are:

- Level 1: Prevention;
- Level 2: De-escalation of tension; and
- Level 3: Action aimed toward safety for all individuals involved.

Our goal of preventing violent behavior can be achieved by effectively employing these four basic steps:

- Observing,
- Skilled listening,
- Talking, and
- Actions.

LEVEL 1: PREVENTION

The first and best method for managing physically or emotionally assaultive behavior is to anticipate and prevent. Management can be achieved by early assessment of the patient. For example, what are his or her needs? Can we meet these needs? If not, what options can we offer the patient, e.g., *“Would you like to speak to a supervisor?”* Consider whether there is another facility that can assist the patient and ask, *“Can we make a referral for you?”* or *“Would another time be more appropriate?”*

Observation As you work, pay attention to the following warning signals that may hint of escalating tensions:

- Defiant attitude
- Excessive swearing
- Aggressive motions
- Unusual demands
- Increase or decrease in voice volume
- Challenging demeanor
- Tightening of jaws
- Deep sighs
- Fidgety movements
- Rapid pacing
- Clenched fists
- Advance or retreat actions

LEVEL 2: DE-ESCALATION OF TENSION

Listening The listening and attending skills of therapeutic communication are the most effective tools of averting violent behavior. Even though you may be having a busy, stressful day, remember to clear your mind and pay attention to what the other person is trying to tell you. Don't rehearse your response. Don't defend yourself verbally.

Practice reflective listening. This involves finding out information about what a person is thinking and feeling, and what may be done about a problem. Don't assume that you know. Ask open-ended questions to elicit more informative responses than a simple yes or no answer. Listen carefully to what is said. Spending two or three minutes interacting with the patient may prevent an altercation. The more information you have, the better you will be able to work out a solution.

Steps for Effective Listening

- Tune in to your personal anxiety level. Assess your feelings and ask yourself if your feelings are interfering with your communication skills.
- Acknowledge the other person's feelings. Identify the anxiety or anger and acknowledge the potential for violence. You might say *"You seem very upset"* or *"I'm concerned that you might hurt yourself or others here."*
- Try to elicit the real issue and determine what is behind the anger.
- Demonstrate appropriate affect. Be sincere and assertive.
- Convey calmness, control and a willingness to help.

Talking Being able to talk down an angry, agitated patient is a valuable skill for anyone providing patient care services. It is a skill dependent upon having and demonstrating a positive regard and respect for others. While talking, be aware of your voice. The tone of your voice will have an immediate affect upon the patient. It is imperative that your voice remains calm and soft yet firm. If you become angry or aggressive like the patient, you will be giving away your control of the situation. Simply state the facts and if necessary, repeat them. Avoid using your title or authority. Do not offer lengthy explanations or excuses.

The Don'ts and Do's of Therapeutic, Effective Talking

The Don'ts – Verbal

- Don't threaten the patient or demand obedience.
- Don't argue with the patient about the facts of the situation. Both of you may be right, but this does not help ease the situation.
- Don't tell the patient that she or he has no reason to be angry.
- Don't become defensive and insist that you are right.
- Don't offer placating responses such as *"Everything will be OK"* or *"You're not the only one."*
- Don't make promises you can't keep.
- Never challenge the patient or call his or her bluff.
- Never criticize the patient.
- Never laugh at the patient.

The Do's – Verbal

- Do ask, *"What can I do to help?"*
- Do use simple, direct statements.
- Do ask opinions: *"In what way do you feel we may be of service to you?"* or *"How would you like to see the situation resolved?"*

- Do offer choices and alternatives: *“If our services are not appropriate, may we assist in referring you to another facility?”* or *“May we make another appointment for you at a more convenient time?”* Try to leave the patient with options.
- Do encourage verbalization of anger rather than acting out. Express your limitation with this verbalization, however, such as expressions or language that is too offensive and not necessary.
- Do provide reassurance while setting limits and identifying behavioral expectations in a kind manner.
- Do assume that the patient has a real concern and that she or he is understandably upset.
- Do recognize and acknowledge the patient’s right to her or his feelings.

LEVEL 3: ACTION

Taking Action Everything that we have learned so far about interacting with difficult patients becomes part of the process and culminates when we take action. A key concept in violence prevention is to try to decrease the person’s sense of powerlessness or helplessness in order to minimize his or her frustrations. Communicate verbally and behaviorally that the person is responsible for his or her own actions. The following steps promote successful interactions:

The Don’ts and Do’s of Successful Interactions

The Don’ts – Actions

- Don’t ignore the patient.
- Don’t come too close to the patient or hover over him or her. Keep a comfortable, non-threatening distance between you and the patient that still allows you to hear and be heard.
- Don’t make threatening physical gestures.
- Don’t analyze or interpret the patient’s motivation.
- Don’t personalize the patient’s anger.

The Do’s – Actions

- Follow instinct and intuition. Use common sense.
- Detect danger signals.
- Keep everyone feeling safe:
 - Open the door to the room;
 - Identify an escape route convenient to you and the patient;
 - Position yourself closest to the room exit;
 - Keep furniture positioned with safety in mind; and
 - Assess the environment for potential weapons.
- Identify a code word that will alert the need for additional help. For example, clinic staff and volunteers are to say *Code Red* through the telephone intercom and identify the area where they are. At that point, designated staff are to respond.
- Protect others in nearby surroundings.
- Ask the patient to sit down.

- Establish and maintain eye contact.
- Observe social distance. Don't touch the patient.
- Decrease environmental stimuli by:
 - Minimizing the presence of staff and other patients,
 - Turning down any loud music, and
 - Minimizing distractions.
- Promote privacy.
- Attempt to meet as many of the patient's reasonable requests or demands as possible.
- Follow through with promises. Do not make promises that you can't keep.
- Remember who you are and practice professional behavior.

Summary

These principles, guidelines and procedures are basic suggestions to assist in averting abusive and violent behavior. They are for the express purpose of effectively serving our patients as well as protecting staff from dangerous and abusive behavior. When put into practice, these steps of observing, listening, talking and action can help achieve our goal of preventing violent behavior. Using common sense while practicing courtesy, concern and compassion will greatly enhance everyone's experience at our clinic.

Always keep in mind the adverse living conditions that our homeless patients deal with day and night. If we can be empathetic, and treat them as we would like to be treated, then we have not only provided good health care, but perhaps we have empowered them in their attempt to take control of their lives.

For the Women of Katrina and Other Disasters

Protection from Violence Against Women and Children

Following natural disasters there is often a sharp rise in violence against women and children, especially for those who have lost their homes and who are living in crowded shelters. Teenage girls, young women, and separated children, are at special risk.

Also, after natural disasters, men tend to take charge. Women's participation in decision making is often put down more than usual. Yet it's essential for everyone's healthy disaster recovery, that women's voices in decision making and women's concerns are heard at every step of the way. (All the above information comes from studies of natural disasters both in the US and around the world.)

What You and Others Can Do

1. Form a Small, Strong, Support Group with the Women Around You. Three or four women together make a strong, efficient team. Tell each other your stories, your needs, and your hopes. Take turns watching each other's children and doing other tasks so you can give each other breaks. Go together, and give each other support, when one or all of you need to make a complaint, report abuse, request rule changes, obtain medical help, join committees, or meet other emergency needs. Even if you have not formed a group, always try to find another women to go with you at these important times.

2. Talk Calmly and Often with Your Children about the Risks of Abuse. Inform your children calmly so you don't increase their fears. Tell them it's important that they tell you right away if anyone tries to touch them inappropriately, tries to get them alone, make deals with them, befriend them too much, or bother them. Ask your children about unexplained gifts, prolonged absences, and new relationships. Check into any job offers your teens may get. Also, while in the shelter, children and teens should always be accompanied to bathrooms, since abusive men tend to hang there.

3. Report All Violence and Abuse Against Yourself and Your Children. It's crucial for your recovery, for your children, and for the entire community that women are safe, strong, unafraid, and un-harassed. You are a vital part of the recovery effort. Remember, too, that if someone abused you, that person will keep on abusing other women and children unless he (or she) is stopped. So report the abuse! If one aide worker doesn't take you seriously, go to the next until you get the help you deserve. Put your complaint in writing. Take at least one other woman with you to make the complaint.

The kinds of violence that can occur are domestic violence, child abuse, prostitution, sex trafficking, and most of all, an increase of sexual violence and harassment. Be especially careful to verify all job offers before going to an unknown place. Sex traffickers often prey on homeless and displaced persons.

4. When You Are Not Being Heard - Put It in Writing! Go to the Person in Charge! Go to the Press! Don't let your needs and ideas get pushed into the background. Here are just three ways you and other women can put the pressure on when you need to. Get paper from an aide. Write your needs or ideas on one page. If you can, get other women to sign it with you. Find out who's in charge. Don't hesitate to go to the top. And remember, there are press people all around. Go to the press. Your voice needs to be heard.

5. Organize and Help Other Women. You may feel too overwhelmed right now to reach out to others. That's ok. But at some point you may find that it can help you feel more in control, or help get your mind off things, if you reach out to help others. Survey other women about their needs. Boost their spirits. Help them form a group, get their voices heard, their needs met, and their losses consoled.

Feel free to photocopy and distribute this information, but please keep all text intact.
Copyright © Marie De Santis, Women's Justice Center
www.justicewomen.comrdjustice@monitor.net

Making Shelters Safe for Transgender Evacuees

Transgender people identify as or express a gender that is different from their sex at birth. This includes people who are born male but live as female, or vice versa, and also people who are androgynous. All transgender people are at significant risk of harassment and physical or sexual assault by people who do not understand, are fearful of, or do not approve of transgender people.

Evacuation shelters must be safe places for transgender evacuees because, like other evacuees, they have nowhere else to go. They may also experience unique difficulties in this time of crisis. It is not difficult to ensure safe shelter for transgender people. Here are some guidelines:

Respect a person's self-identification as male or female. According to the National Coalition for the Homeless, if someone identifies herself as a woman, she should be treated as a woman in all circumstances, regardless of whether she was born male and regardless of whether she has had sex reassignment surgery. A person's stated identity should be recognized and respected, and shelter staff/volunteers should use the name and pronoun ("he" or "she") that the person prefers. If you don't know what terms to use, ask politely.

Understand that people may not have updated identification. Evacuees who fled their homes in crisis may not have identification that correctly identifies their gender or the name they use. The gender and name a person provides should be respected and used, regardless of the name and gender listed on their documents.

Respect a person's evaluation of what housing options are safe or unsafe for that person. Transgender people should be allowed to choose the housing option that they believe is the most safe for them. Generally, if shelters are sex-segregated, people who identify as men should be housed with men, and people who identify as women should be housed with women. This is true regardless of whether people have ID showing this name/gender, regardless of whether they look masculine or feminine, and regardless of whether they've had sex reassignment surgery. However, a person's own evaluation of his or her safety should always be respected. For example, transgender men (born female) may feel safer housed with women. Shelters should also offer transgender residents the ability to sleep within eyesight/earshot of the night staff to lower the risk of assault and harassment.

Respond to inappropriate behavior or harassment by any person. Harassment of any person, including a transgender person, should not be tolerated. Don't base policies or rules on untrue stereotypes about transgender people. It is not fair or correct to assume that just because a person is transgender or has male genitals they are a physical threat to others. Enforce/make rules based only on inappropriate behaviors.

Ensure safe bathroom and shower options. Transgender people should be welcome to use bathrooms and showers that correspond to their self-identified gender or the facilities that feel safest for them. It is rarely illegal for people to use the bathroom that corresponds to the gender they identify as. And, in many places, it may be illegal to deny them access to

the bathroom that corresponds to the gender they identify as. Other people's discomfort is not a valid reason to deny a transgender person access to facilities. If possible, gender-neutral bathrooms should be made available. It may be necessary to add a stall door or shower curtain to address valid privacy and safety concerns.

Understand that transgender people may not “look like” the people they feel they are. Evacuees are generally without their personal toiletries, clothing, make-up, shaving supplies and all of the other items they typically use to groom. For example, a transgender woman (born male) may be unable to shave facial hair without her toiletries. This does not mean she should be treated with disrespect or not seen as a woman.

Keep a person's transgender status confidential, unless he or she tells you otherwise. This minimizes the risk of discrimination and violence. Transgender status is personal health information that is no else's business.

Additional Help and Resources

For additional assistance with providing safe shelters, contact one of the **Lambda Legal National Help Desks in Dallas at (214) 219-8585 or in Atlanta at (404) 897-1880**. They can help with legal issues, provide information about local lesbian, gay, bisexual and transgender community centers that can help LGBT evacuees, and provide information relating to hormones and other prescription drugs including HIV/AIDS medication.

*For a more complete publication devoted to making all shelters safe for transgender people, see
Transitioning Our Shelters: A Guide to Making Homeless Shelters Safe for Transgender People
<http://www.thetaskforce.org/downloads/TransHomeless.pdf>*

A Word about Animals and Environmental Health

Many people who become homeless grieve the loss of animal companions. Others bring animals with them into shelter environments. This is often a difficult balancing act for shelter providers who try to be sensitive to the emotional attachment people have to animals, while still looking out for the overall health and safety of all residents. The following article was developed by the Centers for Disease Control.

Animals in Public Evacuation Centers

As persons are displaced from their homes into evacuation centers, they often wish to bring companion animals with them. Having a pet nearby may serve as a source of comfort to someone who has lost their possessions and, perhaps, family members. Unfortunately, many disaster evacuation centers (and specifically Red Cross evacuation centers) **cannot accept pets** because of states' health and safety regulations. Pets kept at human evacuation centers can sometimes pose a risk of disease or injury to other shelter inhabitants. In fact, service animals that assist people with disabilities are currently the **only** animals allowed in some evacuation centers.

Animal evacuation centers and foster homes may accommodate animals while owners reside in temporary evacuation centers, but these services may not be available everywhere. The following Questions and Answers were developed to address health and safety concerns regarding animals kept in non-Red Cross public evacuation centers.

Q: What are the potential health risks of housing animals and people in one location?

A: Close contact between humans and other animals in evacuation centers may pose a risk for injury or illness. Scared and stressed animals may be more likely to bite or scratch their owners, other people, or other pets. In addition to injury and potential infection from bites and scratches, bites from dogs, cats, and ferrets may present a risk for rabies. Serious bite wounds may require surgical repair. Furthermore, proper care of the animal, such as collection and disposal of urine and feces, may be difficult in public evacuation centers. This poses an additional risk of infection for people, particularly the immunocompromised. People may also be allergic to furred or feathered pets. These problems may be more serious when people do not have access to their usual medications.

Q: What are some diseases that may be transmitted by contact with pets?

A: Routine contact with dogs, and especially cats, may pose a risk for ringworm, which is a skin infection caused by a fungus. Animal feces and fecal-contaminated skin and fur may pose a risk of diarrheal illness from *Campylobacter*, *Salmonella*, and some intestinal parasites. Although these risks are usually small, in the wake of natural disasters such as hurricane Katrina, physical stress and exposure to floodwaters and contaminated food and water may increase the risk for diarrheal infections. Most reptiles (lizards, snakes, iguanas, turtles) shed *Salmonella* in their feces; children younger than 5 years old are at high risk for this disease if they handle reptiles. Although people usually acquire toxoplasmosis by ingesting meat containing tissue cysts, young cats may rarely shed *Toxoplasma* oocysts in their stool. Prompt removal of stool from the environment minimizes this risk. Some pet rodents, such as hamsters, gerbils, and guinea pigs, can transmit lymphocytic choriomeningitis virus (LCMV). *Toxoplasma* and LCMV can cause birth defects in an unborn child if a pregnant woman becomes infected.

Continued on next page.

Q: What are the risks associated with animal bites?

A: The consequences of animal bites, especially dog bites, can be serious. The risk of a bite injury may be greater in situations that promote close contact between people and unfamiliar animals. **Bites from dogs, cats, or ferrets carry a risk for rabies**, even if the animal has been vaccinated and appears healthy. If a dog, cat, or ferret bites a person or another animal, they must be confined and observed for 10 days to see whether they develop signs of rabies. If the biting animal shows signs of rabies or cannot be reliably confined and observed, that animal must be euthanized and tested for rabies. **Serious bite wounds require medical care, and surgical repair in some cases.** Animal bites may also result in infection, and the injured person may need to be treated with antibiotics, a tetanus booster or receive other medical care.

Q: What are some other less common health risks associated with pets?

A: Dogs and cats may serve as a source of ticks that could bite humans and cause disease. Depending on the type of tick, Lyme disease, Rocky Mountain spotted fever, or ehrlichiosis may be of concern, although pets themselves cannot transmit these diseases to people. Cats may spread cat scratch disease (bartonellosis) through bites or scratches. Bites from pet rats may transmit a disease called rat bite fever. Exposure to infected birds may lead to psittacosis, a bacterial infection that causes pneumonia. For this reason, it is often best to also house pet birds, especially parakeets, parrots, love birds, and canaries, away from the general shelter population.

Q: What can be done to minimize the health risks of pets in human evacuation centers?

A: The following guidelines may help reduce risk of injury or disease if it is necessary to house pets in a public shelter:

- The appropriateness of housing pets in public evacuation centers should be carefully considered. Sometimes separate areas can be established for pets. If this is done, then these areas should be staffed with animal care personnel who have been trained in the handling of animals as well as appropriate approaches to infection control. Animal evacuation centers or foster homes may be good alternatives.
- If a pet is kept at a human shelter, it should not be allowed to freely roam the facility and should be kept under control at all times, either via caging or a leash. This is for the animal's safety, as well as that of the people living in the shelter.
- All dogs, cats, and ferrets must have proof of current vaccination against rabies, or be vaccinated upon entry to the shelter.
- Dogs and cats should be treated for intestinal parasites while staying at the human shelter. This is particularly important when the pet is younger than 6 months old.
- Dogs and cats should be treated with medications to kill fleas and ticks. In doing so, care should be taken to administer treatments that are safe for that particular species of animal (i.e., not all treatments that are safe for dogs are safe for cats).

Continued on next page.

- Furred or feathered pets should be housed in areas separate from people with allergies or asthma triggered by fur, feathers, or dander.
- Cats should be kept in a cage with a litter box that is cleaned frequently (at least once every 24 hours). Pregnant women or immunocompromised people should not have contact with used litter.
- Dogs should be walked regularly on a leash outside of the shelter to allow them to urinate and defecate in designated areas, and any feces should be immediately collected and disposed of.
- Anyone bitten by an animal should speak with a healthcare provider to discuss associated concerns (e.g., tissue trauma, infection, rabies risk). Bites and scratches should be thoroughly cleaned with soap and water. Arrangements should be made to confine and observe a biting dog, cat, or ferret for a period of 10 days.
- People caring for pets in evacuation centers should practice good hygiene by cleaning up after their pets (e.g., disposal of feces) and frequently washing their hands.
- Children younger than 5 years old should not handle reptiles without adult supervision, and should always wash their hands after doing so. Hand washing should be monitored by an adult.
- Pregnant women and immunocompromised people should avoid contact with cat feces, and with pet rodents such as hamsters, gerbils, and guinea pigs.
- People should not share food with their pets, nor allow pets to lick their faces.

Centers for Disease Control and Prevention <http://www.bt.cdc.gov/disasters/animalspubevac.asp>

Shelter Health:
Essentials of Care for People Living in Shelter

Mental Illness and Substance Use Disorders

Learning Goal:

- To understand the symptoms of mental illness and substance use disorders and constructive ways to interact with mentally ill and substance using shelter residents.

People who have become homeless are much more likely than housed populations to suffer from mental health problems and substance use disorders. Whether one becomes homeless due to natural disaster, loss of jobs, lack of social support, prohibitive housing costs, or any other reason, trauma is ever-present. Some homeless individuals have mental health problems that preceded the loss of housing, while others suffer from mental health problems that result from the trauma of grief, loss, and life on the streets and in the shelters. And certainly children and families have particular emotional and mental health needs that result from the traumas of homelessness and lack of stability.

Drug and alcohol use can be a destabilizing factor for many people, and can be a cause of homelessness. Drug and alcohol use can also be a coping mechanism for people after they have become homeless. For people who are attempting to reduce or stop substance use, the stress of life on the streets and in the shelters can make recovery nearly impossible. It is difficult enough to deal with addiction in the best of circumstances, but when compounded with uncertainty about meeting basic needs, the ever-present fear of violence, and the hopelessness that can develop from losing everything, it becomes exceedingly difficult for people to change destructive patterns of behavior.

Many shelters—both disaster-related shelters and pre-existing homeless shelters—are very sensitive to the needs of people wrestling with mental illness and substance use. But some are not. Effective shelter systems should not only create policies that balance the overall safety of all shelter residents with the special needs of those with behavioral health problems, but they should also work actively to provide services for the most difficult to serve residents.

This section will examine common manifestations of mental illness and substance use and offer concrete suggestions for how to work effectively with these populations. A later section of this guide (“Taking Care: Coping with Grief and Loss”) will specifically address effective ways of dealing with trauma and loss, for shelter residents as well as staff and volunteers.

The Tool Kits

At the beginning of each section of this Guide, readers will find lists that outline the contents of the Tool Kits that can be found in electronic form on the CD that accompanies this Guide. While some of the tools and handouts are found both in the Guide and in the Tool Kits, most of the items listed below are only found in the Tool Kits. They are to be used to supplement the material in the Guide and to provide shelter providers with day-to-day tools for use in the shelters.

Tool Kit D: Mental Illness and Substance Use Disorders

- D-1 Mental Illness and Homelessness—Healing Hands
- D-2 Mental Illness and Homelessness Facts
- D-3 Borderline Personality Disorders—Healing Hands
- D-4 “Relating to a Person with Mental Illness”
- D-5 Substance Abuse and Homelessness—Healing Hands
- D-6 Addiction Disorders and Homelessness Facts
- D-7 “Blueprint for Change: Ending Chronic Homelessness...”
- D-8 “Interacting with Intoxicated Persons”
- D-9 Suicide Myths and Facts
- D-10 Signs of Possible Suicide Risks
- D-11 “PLAID PALS”

Effective Approaches

There is a great deal of evidence about what practices work well to serve people suffering from severe and persistent mental illness or wrestling with substance use disorders. The list that follows provides a very brief overview of a number of effective approaches. Each of these approaches, if explored in any depth, would easily merit a volume at least the size of this one.

It is therefore not our intention to educate readers fully of the details of these approaches, but merely to provide exposure and spur thinking about how shelters can implement or adapt elements of these practices to better serve their mentally ill and substance-using residents.

Shelter providers often feel under-equipped to work well with those suffering from mental illness and addiction. Our goal here is to present some broad concepts and to encourage shelter providers to seek more in-depth training for staff and volunteers.

What Works

Listed below are selected approaches and practices that have been shown to be effective in addressing the needs of homeless people with serious mental illness and/or substance use disorders. Many of these approaches and practices are applicable to working with all people experiencing homelessness.

Belief in recovery

People can and do recover from problems related to substance use disorders, mental illness, and homelessness – recovery of hope, meaningful activities and relationships, and self-esteem and self-worth.

Person-centered values

The person's own needs and preferences are the primary focus of attention. The helping relationship is collaborative and invitational. Support, information, and options are offered. Services are tailored to the individual.

Outreach and engagement

This approach involves going out into the community and meeting homeless people where they are – on the streets, under bridges, in shelters and drop-in centers. Workers seek to develop trust with individuals and to provide or connect them with needed services.

Flexible, low -demand services

Services are provided in an individualized manner, varying in frequency, duration, and scope depending on one's changing needs and wishes. Participation in treatment is not required as a condition for receiving services, such as accessing entitlements or housing.

Housing with appropriate supports

Emphasis is on placing people as early as possible into permanent housing units with appropriate supportive services offered by an interdisciplinary team of health, behavioral health, and social service providers. Housing itself is seen as a form of treatment.

Interdisciplinary care teams

Teams are composed of various health, behavioral health, and social service providers who work together to ensure that a homeless person's needs are being addressed in an appropriate and coordinated manner.

Integrated treatment for co-occurring mental illness and substance use disorders

This approach implies concurrent, coordinated clinical treatment of both mental illnesses and substance use disorders provided by the same clinician or treatment team. Integrated treatment has been shown to be more effective than a parallel or sequential treatment approach.

Continued on next page.

Motivational interventions/stages of change

Motivational interventions include a range of clinical strategies to help individuals resolve ambivalence and move in the direction of change. These strategies are matched to the client's level of readiness to change.

Self-help programs

Programs are typically based on the AA 12-step method. Focus is on developing personal responsibility within the context of peer support. Participation has been shown to decrease substance use and inpatient treatment, and improve self-esteem and community adjustment.

Involvement of consumers and recovering persons

Consumers can play an important role in outreach, supporting peers in recovery, staffing agency programs, contributing as active members of planning councils, advisory boards, and community advocacy groups.

Long-term follow-up support

The recovery process is neither a linear nor a short-term process for most people. Relapse is not uncommon. Individuals require long term follow up support from an interdisciplinary team of care providers.

Prevention services

Examples of prevention include appropriate discharge planning from institutions/hospitals/treatment programs, short-term intensive support upon re-entry into the community, and provision of subsidized housing and adequate income support.

*Adapted from Blueprint for Change: Ending Chronic Homelessness for Persons with
Serious Mental Illnesses and/or Co-Occurring Substance Use Disorders,
DHHS Pub. No. SMA-04-3870. Printed 2003*

Suggestions for Relating to a Person Experiencing Mental Illness

- Treat the person with respect, as directly and naturally as possible.
- Speak softly, slowly and clearly, communicating only one thought at a time.
- Be as consistent and predictable as you can.
- Set clear and realistic rules, limits and expectations.
- Set simple, short-term goals based on current abilities.
- Criticize as little as possible; praise what you can.
- Remember the person's perceptions may be different from yours.
- Don't try to argue against voices or delusions; they are symptoms of the illness.
- Allow the person a "comfort zone" – don't stare at, hover over, or press the person. Allow him/her an easy exit.
- Don't take the individual's unreasonable attitudes and behavior personally.
- Don't blame the person or others for the illness.
- Accept the reality of the illness, while appreciating the person as he/she is in the present.
- Maintain your own mental health and well being: seek counseling, join a support group, educate yourself and advocate for positive change, maintain contact beyond your work with friends and enjoyable activities.

Washington Advocates for the Mentally Ill

Suggestions for Relating to a Person Experiencing Intoxication

- Approach with care; respect the individual's personal space.
- Use a gentle, soft-spoken voice and body language that communicates to the person "you are safe."
- Make clear, brief statements. Focus on the here and now.
- Always respect the person; don't belittle or "put down" the individual; use humor, but not at the person's expense.
- Take care with responses to provocative statements; stay calm; avoid getting into a confrontation or caught up in the person's "negative energy."
- Avoid labeling the person as an "alcoholic" or "drug addict" or causing the person to feel guilty or "bad."
- Empathize with the person's pain, anger or fear; work to disarm the fear and calm the "fight or flight" responses.
- Give the person time to process; repeat yourself if necessary.
- Check on the person's immediate physical health and safety; an intoxicated person may be physically ill or injured but unaware of it.
- Offer immediate, concrete help, e.g. detox, safe space, sleep-off, medical attention.
- If a person is intoxicated and talking about suicide, do not leave him or her alone. Call or send someone for help, e.g. crisis team, police.
- Be aware and cautious of how you are affecting the person; leave the situation if the person is becoming increasingly agitated or behaviorally inappropriate.
- Validate the person; recognize with them what is going on, what the person is going through; hear the person out; listen for the motive the individual has to take a healthy or appropriate step.
- If possible, follow-up with the person in the near future when they are not under the influence of alcohol or drugs.

Adapted from conversations with Health Care for the Homeless outreach workers.

Understanding Addiction

Most scientists now consider addiction a brain disease: a condition caused by persistent changes to brain structure and function. Using drugs repeatedly over time changes brain structure and function in fundamental and long lasting ways that can persist long after the individual stops using them. After a certain amount of a drug is consumed, and that amount is different for everyone, it is as if a switch in the brain is flipped from normal to addict.

Addiction is defined as uncontrollable, compulsive drug craving, seeking and use, even in the face of negative health and social consequences. Very few people are able to return to occasional use after becoming addicted. But, as we know, not everyone who uses drugs becomes addicted. Some people can become addicted more easily and quickly than others. Estimates are that 50 to 70 percent of these differences in susceptibility to addiction are genetic. Still, genes do not doom one to become an addict.

What understanding addiction as a brain disease means

Many people believe that drug addiction is a failure of will. Research contradicts this. However, this does not mean the addict is simply a hapless victim, nor does it absolve the addict of responsibility for his or her behavior. But it does explain why an addict cannot stop using by sheer force of will alone.

Some parallels can be drawn between addiction and other chronic reoccurring illnesses such as asthma, diabetes and hypertension given that voluntary behaviors (here the decision to try drugs) are involved. Hypertension, cardiovascular disease, diabetes and some forms of cancer are heavily influenced by the person's eating, exercise, smoking and other behaviors.

How do you treat addiction?

Research finds that the best forms of treatment heal the entire individual, combining medication, behavioral therapy, social services and rehabilitation. Another crucial finding on drug treatment is that it does not need to be completely voluntary to work. In fact, studies suggest that increased pressure to stay in treatment – whether from the legal system, or from family members or employers – increases the amount of time patients remain in treatment and improves their treatment outcomes.

What you can do to help a person with drug addiction

1. Understand that while a person who is addicted to drugs made the choice to try the drug, they did not choose to become addicted. An addicted person's brain is functioning abnormally and their drug use is out of their control. They need and deserve the same medical treatment as anyone else with a chronic illness would receive.
2. Find them a treatment program that treats all of their individual problems together, such as drug addiction, behavioral issues, mental illness and/or life skills.
3. Since treatment does not have to be voluntary to work, consider involving other systems to pressure the individual to go into and stay in treatment.

Adapted summary of the paper Addiction is a Brain Disease by Dr. Alan Leshner, former Director of the National Institute on Drug Abuse (2001). See full report at <http://www.issues.org/17.3/leshner.htm>

Principles of Effective Drug Addiction Treatment

1. **No single treatment is appropriate for all individuals.** Matching treatment settings, interventions, and services to each individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society.
2. **Treatment needs to be readily available.** Because individuals who are addicted to drugs may be uncertain about entering treatment, taking advantage of opportunities when they are ready for treatment is crucial. Potential treatment applicants can be lost if treatment is not immediately available or is not readily accessible.
3. **Effective treatment attends to multiple needs of the individual, not just his or her drug use.** To be effective, treatment must address the individual's drug use and any associated medical, psychological, social, vocational, and legal problems.
4. **An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs.** A patient may require varying combinations of services and treatment components during the course of treatment and recovery. In addition to counseling or psychotherapy, a patient at times may require medication, other medical services, family therapy, parenting instruction, vocational rehabilitation, and social and legal services. It is critical that the treatment approach be appropriate to the individual's age, gender, ethnicity, and culture.
5. **Remaining in treatment for an adequate period of time is critical for treatment effectiveness.** The appropriate duration for an individual depends on his or her problems and needs. Research indicates that for most patients, the threshold of significant improvement is reached at about 3 months in treatment. After this threshold is reached, additional treatment can produce further progress toward recovery. Because people often leave treatment prematurely, programs should include strategies to engage and keep patients in treatment.
6. **Counseling (individual and/or group) and other behavioral therapies are critical components of effective treatment for addiction.** In therapy, patients address issues of motivation, build skills to resist drug use, replace drug-using activities with constructive and rewarding nondrug-using activities, and improve problem-solving abilities. Behavioral therapy also facilitates interpersonal relationships and the individual's ability to function in the family and community.
7. **Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.** Methadone and levo-alpha-acetylmethadol (LAAM) are very effective in helping individuals addicted to heroin or other opiates stabilize their lives and reduce their illicit drug use. Naltrexone is also an effective medication for some opiate addicts and some patients with co-occurring alcohol dependence. For persons addicted to nicotine, a nicotine replacement product (such as patches or gum) or an oral

medication (such as bupropion) can be an effective component of treatment. For patients with mental disorders, both behavioral treatments and medications can be critically important.

8. **Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way.** Because addictive disorders and mental disorders often occur in the same individual, patients presenting for either condition should be assessed and treated for the co-occurrence of the other type of disorder.
9. **Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use.** Medical detoxification safely manages the acute physical symptoms of withdrawal associated with stopping drug use. While detoxification alone is rarely sufficient to help addicts achieve long-term abstinence, for some individuals it is a strongly indicated precursor to effective drug addiction treatment
10. **Treatment does not need to be voluntary to be effective.** Strong motivation can facilitate the treatment process. Sanctions or enticements in the family, employment setting, or criminal justice system can increase significantly both treatment entry and retention rates and the success of drug treatment interventions.
11. **Possible drug use during treatment must be monitored continuously.** Lapses to drug use can occur during treatment. The objective monitoring of a patient's drug and alcohol use during treatment, such as through urinalysis or other tests, can help the patient withstand urges to use drugs. Such monitoring also can provide early evidence of drug use so that the individual's treatment plan can be adjusted. Feedback to patients who test positive for illicit drug use is an important element of monitoring.
12. **Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis and other infectious diseases, and counseling to help patients modify or change behaviors that place themselves or others at risk of infection.** Counseling can help patients avoid high-risk behavior. Counseling also can help people who are already infected manage their illness.
13. **Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment.** As with other chronic illnesses, relapses to drug use can occur during or after successful treatment episodes. Addicted individuals may require prolonged treatment and multiple episodes of treatment to achieve long-term abstinence and fully restored functioning. Participation in self-help support programs during and following treatment often is helpful in maintaining abstinence.

From Principles of Drug Addiction Treatment: A Research-Based Guide, National Institute on Drug Abuse (NIDA) <http://www.nida.nih.gov/PODAT/PODATIndex.html>

Suicide

People living in shelter have increased rates of depression. Depression can be one of the causes of homelessness, and it can be a result of homelessness. Those who have suffered grief and loss, experienced trauma, or survived natural disaster are particularly susceptible to depression and suicidal thoughts or actions.

In the weeks following Hurricane Katrina, several prominent residents of New Orleans committed suicide—most notably several police officers and at least two well-known physicians.

Those who provide shelter must constantly be aware of the risk of suicide among shelter residents and be equipped to intervene and prevent suicide from occurring. The following pages give some concrete suggestions for recognizing and responding to suicide risks.

Suicide Myths and Facts

Myth: Suicidal people are fully intent on dying. Nothing others do or say can help.

Fact: Suicide is preventable. Most suicidal people desperately want to live; they are just unable to see alternatives to their problems.

Myth: Suicide happens without warning.

Fact: There are almost always warning signs, but others are often unaware of the significance of the warnings or unsure about what to do.

Myth: People who talk about suicide do not commit suicide.

Fact: Most people who commit suicide have talked about or given definite warning signs of their suicidal intentions.

Myth: Improvement in a suicidal person means the danger is over.

Fact: Many suicides occur several months after the beginning of improvement, when a person has energy to act on suicidal thoughts.

Myth: Suicide is more common in lower socio-economic groups.

Fact: Suicide cuts across social and economic boundaries.

Myth: All suicidal individuals are depressed.

Fact: Depression is often associated with suicidal feelings but not all persons who attempt or commit suicide are depressed. A number of other emotional factors may be involved.

Myth: Young people are more likely than old people to commit suicide.

Fact: People 65 and older kill themselves at a higher rate than those aged 15-24.

Myth: Asking “Are you thinking about committing suicide?” may trigger a person to make a suicide attempt.

Fact: Asking direct, caring questions about suicide will often minimize a person’s anxiety and act as a deterrent to suicidal behavior.



Signs of Depression & Possible Suicide Risk

Talking About Dying – any mention of dying, disappearing, jumping, shooting oneself, or other types of self harm

Recent Loss – through death, divorce, separation, broken relationship, loss of job, money, status, self-confidence, self-esteem, loss of religious faith, loss of interest in friends, sex, hobbies, activities previously enjoyed

Change in Personality – sad, withdrawn, irritable, anxious, tired, indecisive, apathetic

Change in Behavior – can't concentrate on routine tasks, school, work

Change in Sleep Patterns – insomnia, often with early waking or oversleeping, nightmares

Change in Eating Habits – loss of appetite and weight, or overeating

Diminished Sexual Interest – impotence, menstrual abnormalities (often missed periods)

Fear of Losing Control – going crazy, harming self or others

Low Self Esteem – feeling worthless, shame, overwhelming guilt, self-hatred, "everyone would be better off without me"

No Hope for the Future – believing things will never get better; that nothing will ever change

REMEMBER: The risk of suicide may be greatest as the depression lifts.

Adapted from San Francisco Suicide Prevention <http://www.sfsuicide.org/html/warning.html>

P.L.A.I.D. P.A.L.S.

Things to watch for when assessing potential suicide risk...

Plan – Do they have one?

Lethality – Is it lethal? Can they die?

Availability – Do they have the means to carry it out?

Illness – Do they have a mental or physical illness?

Depression – Chronic or specific incident(s)?

Previous attempts – How many? How recent?

Alone – Are they alone? Do they have a support system? A partner? Are they alone right now?

Loss – Have they suffered a loss? Death, job, relationship, self esteem?

Substance abuse (or use) – Drugs, alcohol, medicine? Current, chronic?

San Francisco Suicide Prevention <http://www.sfsuicide.org/html/warning.html>

Glossary of Common Mental Health Terms

Affective disorder (also called mood disorder)

A category of mental health problems that include a disturbance in mood, usually profound sadness or apathy, euphoria or irritability, such as the disorder depression.

Agoraphobia

A Greek word that literally means "fear of the marketplace." This anxiety disorder is characterized by a fear of open, public places or of being in crowds. Agoraphobics often experience panic attacks in a place or situation from which escape may be difficult or embarrassing.

Alzheimer's disease

A progressive, irreversible disease, most prevalent late in life, characterized by deterioration of the brain cells and leading to impaired mental functioning.

Anger

The experience of intense annoyance that inspires hostile and aggressive thoughts and actions.

Anorexia nervosa (also called anorexia)

An eating disorder in which people intentionally starve themselves.

Antidepressants

Medications that treat depression, as well as other psychiatric disorders.

Antisocial personality disorder

A disorder characterized by a disregard for the feelings, property, authority and respect of others, for an individual's own personal gain. This may include violent or aggressive destructive actions toward other people, without a sense or remorse or guilt.

Anxiety

A feeling of unease and fear of impending danger characterized by physical symptoms such as rapid heart rate, sweating, trembling and feelings of stress. In contrast to fear, the danger or threat in anxiety is imagined, not real.

Anxiety disorders

Conditions characterized by high levels of anxiety. Currently five different anxiety disorders are recognized: generalized anxiety disorder, obsessive-compulsive disorder, panic disorder, post traumatic stress disorder and social phobia.

Attention-deficit disorder (ADD) & attention-deficit/hyperactivity disorder (ADHD)

A behavior disorder, usually first diagnosed in childhood, that is characterized by inattention, impulsivity and, in some cases, hyperactivity.

Continued on next page.

Autistic disorder (also called autism)

A neurological and developmental disorder that usually appears during the first three years of life. A child with autism appears to live in his/her own world, demonstrating little interest in others and a lack of social awareness. The focus of an autistic child is a consistent routine and includes an interest in repeating odd and peculiar behaviors. Autistic children often have problems in communication, avoid eye contact and show limited attachment to others.

Bingeing

A destructive pattern of excessive overeating.

Bipolar disorder

A mood disorder, formerly called manic-depressive disorder, characterized by episodes of major depression and mania.

Borderline personality disorder

A serious mental illness characterized by pervasive instability in moods, interpersonal relationships, self-image, and behavior. This instability often disrupts family and work life, long-term planning, and the individual's sense of self-identity.

Bulimia nervosa (also called bulimia)

A condition characterized by binge eating followed by extreme measures to undo the binge (often vomiting).

Compulsion

An uncontrollable, repetitive and unwanted urge to perform an act. A compulsive act is a defense against unacceptable ideas and desires, and failure to perform the act leads to anxiety.

Delirium

A condition in which changes in cognition, including a disturbance in consciousness, occur over a relatively short period of time.

Delusions

Beliefs such as delusions of grandeur that are thought to be true by the person having them, but these beliefs are wrong. People with delusions cannot be convinced that their beliefs are incorrect.

Dementia

A disorder in which there is loss or impairment of mental powers due to organic causes (physical disease) and severe enough to interfere with work or social functioning. Memory disturbance is the most prominent symptom. Other symptoms include personality change and impairment of abstract thinking, judgment and control of impulses. Dementia may be progressive, static or reversible, depending on the particular conditions of the disease and its treatment.

Continued on next page.

Denial

The refusal to accept reality and to act as if a painful event, thought or feeling did not exist.

Depression

A mood disturbance characterized by feelings of sadness, loneliness, despair, low self-esteem, worthlessness, withdrawal from social interaction, and sleep and eating disturbances.

Dyslexia

A reading disorder. A child with dyslexia reads below the expected level given his/her age, school grade and intelligence.

Epilepsy

A disorder characterized by periodic motor or sensory seizures, or their equivalents, resulting from abnormal electrical discharge generated within the brain; sometimes accompanied by a loss of consciousness. Some cases of epilepsy have a known organic cause, while others are a result of organic injury.

Hallucinations

A strong perception of an event or object when no such situation is present; may occur in any of the senses (i.e., visual, auditory, gustatory, olfactory or tactile).

Hostility

The disposition to inflict harm on another person and/or the actual infliction of harm, either physically or emotionally.

Hypomania

An episode of illness that resembles mania, but is less intense and less disabling. Hypomania is characterized by a euphoric mood, unrealistic optimism, increased speech and activity, and a decreased need for sleep.

Impulse-control disorders

Disorders characterized by the inability to inhibit impulses that might be harmful to oneself or others.

Learning disorder

When a child's academic ability is below what is expected for the child's age, schooling and level of intelligence. A learning difficulty is usually identified in reading, math or writing.

Major depressive disorder (also known as clinical depression)

A major mood disorder characterized by one or more (recurrent) episodes of major depression, with or without full recovery between episodes.

Mania

An episode usually seen in the course of bipolar disorder characterized by a marked increase in energy, extreme elation, impulsivity, irritability, rapid speech, nervousness, distractibility and/or poor judgment. During manic episodes, some people also experience hallucinations or delusions.

Continued on next page.

Manic depression (also known as bipolar disorder)

Classified as a type of affective disorder (or mood disorder) that goes beyond the day's ordinary ups and downs. Manic depression is characterized by periodic episodes of extreme elation, elevated mood, or irritability (also called mania) countered by periodic, classic depressive symptoms.

Mood disorder (also known as affective disorder)

A category of mental health problems including a disturbance in mood, usually profound sadness or apathy, euphoria or irritability, such as the disorder major depression.

Neurotransmitters

Chemicals in the brain that regulate other chemicals in the brain.

Obsessive-compulsive disorder (OCD)

An anxiety disorder in which a person has an unreasonable thought, fear or worry that he/she tries to manage through ritualized activity. Frequently occurring disturbing thoughts or images are called obsessions, and the rituals performed to try to prevent or dispel them are called compulsions. People with OCD often become uncomfortable in situations that are beyond their control and have difficulty maintaining positive, healthy interpersonal relationships as a result.

Panic disorder (also called panic attacks)

An anxiety disorder characterized by chronic, repeated and unexpected intense periods of fear when there is no specific cause for the fear. In between panic attacks, people with panic disorder worry excessively about when and where the next attack may occur. Panic disorder may be accompanied by agoraphobia.

Paranoia

Symptoms include feelings of persecution and an exaggerated sense of self-importance. Paranoia is present in many mental disorders and it is rare as an isolated mental illness.

Personality Disorder

A deeply ingrained, inflexible, maladaptive pattern of relating, perceiving and thinking, serious enough to cause distress or impaired functioning. Personality disorders are usually recognizable by adolescence or earlier, continue throughout adulthood and become less obvious in middle or old age. Examples of formally identified personality disorders are antisocial, borderline, compulsive, histrionic, dependent, narcissistic, paranoid, passive-aggressive, schizoid and schizotypal.

Phobia

An uncontrollable, irrational and persistent fear of a specific object, situation or activity.

Post-traumatic stress disorder (PTSD)

A debilitating condition that is related to a past terrifying physical or emotional experience causing the person who survived the event to have persistent, frightening thoughts and memories or flashbacks, of the ordeal. People with PTSD often feel chronically emotionally numb.

Continued on next page.

Purging

People with bulimia engage in a destructive pattern of ridding their bodies of the excess calories (to control their weight) by vomiting, abusing laxatives or diuretics, taking enemas and/or exercising obsessively – a process called purging.

Relapse

The recurrence of a disease after apparent recovery, or the return of symptoms after remission.

Schizoid personality disorder

People with this disorder are often cold, distant, introverted and have an intense fear of intimacy and closeness. They are often so absorbed in their own thinking and daydreaming that they stay detached from others and reality.

Schizophrenia

A complex mental health disorder involving a severe, chronic and disabling disturbance of the brain. The symptoms may include hallucinations, delusions and disorganized thinking.

Selective serotonin reuptake inhibitors (SSRIs)

A commonly prescribed class of drugs for treating depression. SSRIs work by stopping the reuptake of serotonin, an action that allows more serotonin to be available to be taken up by other nerves.

Somatization disorder

A chronic disorder characterized by multiple, often long-standing physical complaints. Most frequently, the complaints involve chronic pain, problems with the digestive system, the nervous system, and the reproductive system.

Suicidal behavior

Actions taken by one who is considering or preparing to cause his or her own death.

Suicidal ideation

Thoughts of suicide or wanting to take one's life.

Suicide

The intentional taking of one's life.

Suicide attempt

An act focused on taking one's life that is unsuccessful in causing death.

Tourette's syndrome

A tic disorder characterized by repeated involuntary movements and uncontrollable vocal sounds. This disorder usually begins during childhood or early adolescence.

Glossary of Selected Terms Related to Substance Use Disorders, Treatment, and Recovery

Abstinence: The act of refraining from the use of the substance(s) on which a person has become dependent.

Addiction: Uncontrollable, compulsive drug craving, seeking, and use – even in the face of negative health and social consequences. Very few people are able to return to occasional use after becoming addicted.

Al-Anon: A self-help organization for individuals whose lives are affected by the addiction of a family member or friend.

Alcoholics Anonymous (AA)/Narcotics Anonymous (N/A): A voluntary, anonymous self-help organization of individuals who have recognized their chemical dependence and are committed to living a life of abstinence. Abstinence is achieved by a Twelve-Step Program and members of AA/NA support each other by sharing their own struggles, experiences and hopes.

Alcoholism: A disease characterized by excessive and habitual drinking of alcoholic beverages that causes the individual physical, psychological, and social harm.

Amphetamines: Potent psychomotor stimulants that induce exhilarating feelings of power, strength, energy, self-assertion, focus and enhanced motivation. The need to sleep or eat is diminished. A sense of aroused euphoria may last several hours but is then followed by an intense mental depression and fatigue. Amphetamines may be sniffed, swallowed, snorted or injected. More than any other illegal drug, speed is associated with violence and anti-social behavior.

Antabuse (disulfiram): A drug which alters the way in which the body breaks down alcohol. Someone who is taking Antabuse and consumes alcohol will have a violent physical reaction to the alcohol – nausea, vomiting and rapid changes in blood pressure occur. Antabuse is sometimes prescribed as a part of treatment after detoxification is complete to reduce the possibility of relapse.

Benzodiazepines: Among the most commonly prescribed depressant medications in the United States today. Drug actions include: anxiety relief, hypnotic, muscle relaxant, anti-convulsant, or an amnesiac (mild memory-loss inducer). Due to their sedative properties, benzodiazepines have a high potential for abuse, especially when used with other depressants such as alcohol or opiates.

Binge drinking: Drinking to intoxication. Drinking five or more drinks at a time is considered binge drinking.

Continued on next page.

Blackout: Loss of memory while drinking alcohol. The person does not remember events that occurred even if he or she appeared to others to be alert and functioning. Repeated blackouts are a sign of alcohol use disorder.

Buprenorphine: A drug used to treat opiate addiction by preventing symptoms of withdrawal from heroin and other opiates.

Chemical Dependency: A physical and psychological habituation to a mood- or mind-altering drug, such as alcohol or cocaine.

Cocaine: A colorless or white crystalline alkaloid, extracted from coca leaves, sometimes used in medicine as a local anesthetic especially for the eyes, nose, or throat and widely used as an illicit drug for its euphoric and stimulating effects. There are many street names for cocaine, including coke, C, toot, flake, blow, and snow.

Co-dependency: The condition in which people allow the behavior or sickness of another to affect them to the extent that they lose their own sense of identity and their own life becomes unmanageable. Co-dependency is characterized by trying to control the behavior of another and having unrealistic expectations about the power of that control.

Crack cocaine: "Crack" is the name given to cocaine that has been processed with baking soda or ammonia, and transformed into a more potent, smokable, "rock" form. The name refers to the crackling sound heard when the rock is heated and smoked. Cocaine is a stimulant that has been abused for ages; however, crack cocaine is the most potent form in which the drug has ever appeared.

Craving: A powerful, uncontrollable desire for drugs or alcohol.

Cutting back or cutting down: A strategy to considerably reduce the amount and/or frequency of alcohol and/or other drug use. If a person can make and maintain a change without any exceptions for several weeks or months, then cutting back may be a good long-term plan to manage substance use. If the person cannot cut back, or cannot do so for a prolonged period, the problem may require additional help.

Denial: Not recognizing or refusing to admit the relationship between substance use and life problems (such as health, relationships, or employment issues.) Denial occurs when facing a painful reality is too much for a person to bear. Accepting the truth would turn upside down the person's entire way of viewing themselves, the world and the future. A person is "in denial" when the facts of a situation are apparent but the person is unable to admit the truth to himself/herself.

Dependence: This term is often used to mean the same thing as addiction. It can be thought of in two ways: (1) psychological feelings of discomfort when the drug is not available (psychological dependence), or (2) a state where the body requires the regular use of alcohol or other drugs in order to continue to function (physical dependence).

Continued on next page.

Detoxification: The process of allowing the body to rid itself of a large amount of alcohol and/or other drugs. The person who is going through this process, which can last for several days, feels ill and has trouble eating, sleeping and concentrating. This process is medically dangerous, especially when the person is detoxifying from alcohol or sleeping pills and should occur in a hospital or detoxification center under medical supervision.

Drug Courts: Designed to help addicted individuals facing criminal charges get through treatment. Their basic premise is to leverage the authority of the criminal-justice system to keep defendants in treatment, recognizing that the recovery process may well include lapses and relapses, but the longer an addict stays in treatment, the greater chance he/she has for sustained recovery.

Dual Diagnosis/Co-Occurring Disorders: The presence of a substance abuse or chemical dependency diagnosis with a coexisting psychiatric disorder.

Enabling: Any behavior or action that assists the person in the continuation of their addiction. Enabling is either intentional or unintentional, and is usually done out of love and misguided concern. Enabling allows the addict to continue their destructive behavior.

Fetal Alcohol Syndrome: A disorder seen in a small number of the children born of mothers who drink heavily during pregnancy. A child with fetal alcohol syndrome usually has low intelligence and learning problems.

Hallucinogen: A drug that produces hallucinations – distortion in perception of sights and sounds – and disturbances in emotion, judgment, and memory.

Harm reduction: Strategies designed to diminish the individual and social harms associated with drug use, including the risk of HIV infection, without requiring the cessation of drug use. In practice, harm reduction programs include syringe exchange, replacement therapy using substances such as methadone, health and drug education, HIV and sexually transmitted disease screening, psychological counseling, and medical care.

Heroin: A highly addictive drug derived from the opium poppy. It is a "downer" that affects the brain's pleasure systems and interferes with its ability to perceive pain. Heroin can be injected into a vein (mainlining) or a muscle; smoked through a water pipe or standard pipe; mixed in a marijuana joint or regular cigarette; inhaled as smoke through a straw (chasing the dragon) or as powder through the nose. Also known as smack, brown, horse, gear, H, steps, junk, skag and jack.

Inhalants: Chemical vapors that, when inhaled, cut off the brain's supply of oxygen, producing psychoactive (mind-altering) effects. These effects can vary greatly; some have depressant effects while others can be stimulants. Inhalants include solvents found in household cleaning products, aerosols, gases such as nitrous oxide ("laughing gas"), and nitrites ("poppers", "snappers").

Continued on next page.

Marijuana: The most commonly used illicit drug in the United States. Taken from the leaves and flowering tops of the *Cannabis sativa* plant. It also comes in a more concentrated, resinous form, called hashish, and as a sticky black liquid called hash oil.

Methadone Maintenance Therapy: A type of treatment for individuals who are addicted to heroin or other opiate drugs (such as Percodan® or OxyContin®). Methadone is a safe and effective medication that acts as a stabilizer so people can return to daily life. Methadone does not make people high and does not replace one drug addiction with another - methadone's effects are very different from opiates. Most people receive methadone daily from a clinic, where counseling and group meetings are also available.

Methamphetamine: A highly addictive and very potent central nervous stimulant, also known as "meth," "crystal meth," "ice," and "glass." It is found in powder, pill, and capsule forms and can be inhaled, swallowed and injected. The effects are alertness, euphoria, loss of appetite, dilated pupils, elevated heart rate, increased breathing and elevated body temperature. (See Amphetamines)

Motivational Interviewing: A client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence. This approach emphasizes relationship-building (expressions of empathy), heightening discrepancy between an individual's personal goals and present circumstances, rolling with resistance (emphasizing respect for the individual experiencing the problem and their necessity and ability to solve the problem), and supporting self-efficacy (expressing confidence in the person's ability to recover and expressing confidence in recovery).

Nicotine: The main active ingredient of tobacco. Extremely toxic and causes irritation of lung tissues, constriction of blood vessels, increased blood pressure and heart rate, and, in general, central nervous system stimulation.

Opiate: Any substance, natural or synthetic, that is related in action to morphine. Term is often used just to mean opium, morphine, codeine, and heroin - the natural ingredients of the poppy and their derivatives, excluding the synthetic narcotic analgesics.

Opiate replacement therapy: The medical procedure of replacing an illegal opiate drug such as heroin with a longer acting but less euphoric opiate such as methadone or buprenorphine.

Opioids: Controlled drugs or narcotics most often prescribed for the management of pain; natural or synthetic chemicals based on opium's active component - morphine - that work by mimicking the actions of pain-relieving chemicals produced in the body.

Overdose: Too great a dose; a lethal or toxic amount.

OxyContin®: Contains oxycodone, a strong narcotic pain reliever similar to morphine. Intended to help relieve pain that is moderate to severe in intensity, when that pain is present all the time, and expected to continue for a long time. Has a widespread problem of abuse and misuse.

Continued on next page.

Physical Dependence: When a person requires the regular use of alcohol or other drugs to continue to function, and develops withdrawal symptoms without the substance.

Psychological Dependence: Psychological feelings of discomfort when the drug is not available.

Recovery: A lifelong process of change to abstain from alcohol/drug usage. A whole range of changes in behavior and outlook made by the individual to abstain permanently from drinking and drug use, to improve emotional well-being, to relate to others in a more positive way, to find new ways of spending leisure time, and to develop alternative ways of coping with stress. A person who is an alcoholic or addict has to “work on recovery” in order to achieve it. Recovery is much more than simply abstaining from alcohol and other drugs – it involves active, continually evolving behavior changes.

Relapse: When referring to alcoholism and other drug abuse, this term means that a person who has not been using any drugs or alcohol, and is committed to continuing this pattern, returns to using alcohol or other drugs again. In Motivational Interviewing terms, relapse is viewed as a temporary loss of motivation.

Social Model: A modality of treatment known as the recovery process characterized by lifelong commitment to life style changes to enable an individual to develop a constructive, productive and meaningful sober way of life that fulfills their potential; generally accomplished in a community based program.

Stages of Change: A model that describes the main stages that individuals go through in the change process (in this case, to address their substance dependence): pre-contemplation, contemplation, preparation, action, and maintenance.

Substance abuse: A pattern of harmful use of any chemical substance to alter states of body or mind for other than medically warranted purposes.

Tolerance: A condition in which higher doses of a drug are required to produce the same effect as experienced initially; often leads to physical dependence.

Tranquilizers: Drugs prescribed to promote sleep or reduce anxiety; also known as benzodiazepines or barbiturates, a class of central nervous system depressants.

Treatment: Planned activities designed to change some pattern of behavior(s) which has led to substance use problems, and medications that help with withdrawal symptoms, craving, and preventing relapse. Typical activities for the treatment of alcoholism and/or drug dependence include detoxification, individual or group counseling for the addicted person, education and counseling for the family, and a structured residential program for those who have been unsuccessful in abstinence in less structured settings.

Continued on next page.

Twelve Step Programs: The 12 Steps are the philosophical basis of Alcoholics Anonymous and all Anonymous self-help groups. They are the means by which one can get into recovery and achieve an abstinent life. The first step is to acknowledge one's powerlessness over the substance and that one's life has become unmanageable.

Withdrawal: The symptoms experienced by substance abusers when they stop using the drug upon which they have become dependent. These symptoms are usually unpleasant and uncomfortable; they may include nausea, insomnia, anxiety, weakness, trembling, sweating, dizziness, convulsions, and dementia.

Shelter Health:
Essentials of Care for People Living in Shelter

Taking Care: Coping with Grief and Loss

Learning Goal:

- To promote awareness of the effects of trauma and loss and identify useful approaches to enhance the emotional well-being of shelter staff and residents.

As we have talked with people living and working on the Gulf Coast since Hurricanes Katrina, Rita, and Wilma during the hurricane season of 2005, the common theme identified across the board has been the need for psychological support to deal with grief and loss—not only for victims of the disasters, but also for the caregivers who are working to support the victims.

This need is also true for traditional homeless services. Both victims of disaster and victims of other types of homelessness have experienced great loss—loss of family and friends, loss of homes and belongings, loss of jobs, loss of personal identity. And in settings in which these individuals are served, service providers find themselves in the position of hearing the stories, taking on another's trauma, and working to help that person find healing. The caregiver is inevitably traumatized.

In some cases, victims of trauma develop Post-Traumatic Stress Disorder, and caregivers experience Secondary Traumatic Stress. In many other cases, while a formal diagnosis may not be in order, the effects of trauma are profound and lasting.

This part of the guide attempts to raise awareness about the effects of trauma and to provide tools to care for those who have experienced trauma directly and for those who experience the trauma vicariously.

"Let us not underestimate how hard it is to listen and to be compassionate. Compassion is hard because it requires the inner disposition to go with others to the place where they are weak, vulnerable, lonely and broken. But ... our spontaneous response ... is to do away with suffering by fleeing from it or finding a quick cure for it. As busy, active, relevant people we want to [make] a real contribution. This means...doing something to show that our presence makes a difference. And so we ignore our greatest gift ... our ability to be there, to listen and to enter into solidarity with those who suffer."

Henri Nouwen

The Tool Kits

At the beginning of each section of this Guide, readers will find lists that outline the contents of the Tool Kits that can be found in electronic form on the CD that accompanies this Guide. While some of the tools and handouts are found both in the Guide and in the Tool Kits, most of the items listed below are only found in the Tool Kits. They are to be used to supplement the material in the Guide and to provide shelter providers with day-to-day tools for use in the shelters.

Tool Kit E: Taking Care—Coping with Grief and Loss

- E-1 CDC handout: Coping with a Traumatic Event
- E-2 “Homeless Families and Trauma”
- E-3 Self-Care Self-Assessment Tool
- E-4 “Healing Hands” February 2002: Resiliency and Renewal
- E-5 “Healing Hands” April 1999: Trauma and Homelessness
- E-6 Facts on Trauma and Homeless Children
- E-7 “For the Women of Katrina”

When the Hurricane Hits

This is difficult work. Let's remember that. To walk with people for a little while on the journey—a difficult, often painful journey. To enter into the shadows with people. To take on the suffering of others in order to lighten the load for them, even for a short time. To hope in people—to be hope for them—until they are able to rekindle hope for themselves. This is tough stuff.

Those who work with people experiencing homelessness, mental illness, addiction, HIV/Aids, and domestic violence do this every day. We walk beside people for a little while. We try to stay strong and centered so that we can be a support to people who are in crisis. We are working with people who seem to have lost everything—homes, families, job, hope.

Then, just when it seems that there is nothing more for someone to lose, another disaster strikes. New York is devastated by the events of September 11th. Homelessness recedes into the background of the social fabric, and those who were already forgotten are forgotten yet again. Hurricane Katrina passes over New Orleans. People hunker down and feel that they “dodged a bullet this time.” Then the waters start to rise. And they keep rising. People are driven from their homes. People without homes are driven to who-knows-where.

What do you do when disaster strikes people who seem to have already lost everything? How do you cope with your own sense of loss? And how do you “stay centered” so that you can help those around you?

I was 2000 miles from lower Manhattan when the planes ripped into the Twin Towers. I was at a soup kitchen in downtown Albuquerque. The otherwise bustling room was eerily quiet. The staff had wheeled a large-screen TV out, and 250 of us watched in helpless silence as the buildings crashed to the ground in a flaming cloud of smoke and debris. When I got home that night, my 2-year-old son, Atticus, wanted to play with trains on the floor. I couldn't bring myself to turn the TV on. I wanted to protect him from the constantly replayed image of the plane crashing into the building.

I was working with homeless families at the time, and I became obsessed with how the kids I knew—homeless and housed—were dealing with the 9/11, and how their parents were coping. So I found myself asking parents, “How are you talking to your kids about this tragedy?”

What I found startled me, but shouldn't have. Many of the people I knew at the time who were homeless were so consumed with their own traumatic lives that they had little energy or emotion left spend on an overwhelming tragedy 2000 miles away. It makes sense, really. It just surprised me.

Continued on next page.

The reality was different, to be sure, for homeless individuals and homeless service providers in New York.

When Hurricane Katrina hit, Atticus and I were visiting my parents in Tuscaloosa, Alabama, where I grew up. We were four hours from the coast, but right in the storm's path. The power was knocked out, and would stay off for two days. We sat in candlelight, hoping the roof wouldn't blow off. At about 8 p.m. a thunderous crack startled us. When we woke the next morning, we realized that a javelin of a limb had pierced the roof. Other than some big limbs down in the yard and the damage to the roof, though, everything—and everyone—was fine.

That day, as we cleaned up after the storm, we got sporadic updates from friends and neighbors about the toll of the storm. New Orleans had missed the worst of it, though Biloxi was hit hard. It was a calm, strangely beautiful day—the humidity of August in the south was nowhere to be found, and the sky was a clear blue.

Then, like the morning of September 11th, the magnitude of the tragedy in New Orleans and the surrounding areas slowly unfolded before our eyes.

As the news cameras panned through the masses of people in the Superdome, and as the aerial shots revealed flooded streets that looked like Venetian canals, it became evident that tens of thousands of people found themselves without homes—just like that. I wondered, though, what happened to those who didn't have homes to begin with. Nothing to climb on top of as the waters rose. Some, surely, made it to the shelters and to the buses and to the helicopters. Some, though, surely didn't. As I opened the New York Times this morning and saw the image of a corpse in the street, I found myself wondering if maybe this person was homeless before the levees broke.

Now, as the stories have faded from the front pages, I find myself wondering how the people of New Orleans, Biloxi, Gulf Port, Mobile—those who have seemingly lost everything—keep getting up every day and going about their lives. Clearly, some are not: suicide rates are on the rise in New Orleans and other gulf communities as winter approaches and as the long-term realities of Katrina become evident. But many not only keep getting up, but also find strength to lift up those around them, helping in many ways, seen and unseen.

We all find renewal in our own ways, but I think there is a basic, inherent human desire to help one another. Even when there is meanness, even when panic breaks out on the heels of a disaster, the instinct to lift each other up wins out in the long haul. This is what drives firefighters to go up the stairs into the World Trade Center while everyone else is coming down. It's what drives a Louisiana fisherman to drive his pirogue around the waterlogged streets of New Orleans to pluck people off their roofs one at a time and take them to higher ground. And it's what drives people who choose to devote their time and energy to provide care for the poorest of the poor in our communities every day.

Jeff Olivet

Care for the Caregiver

Those who choose to work with people in crisis are often so focused on the trauma of the people they are there to serve that they do not recognize the impact of that trauma on themselves. This is equally true for paid staff and volunteers. It is true whether those caregivers are working short-term, as in the case of disaster response, or year after year, as in the case of year-round homeless services.

The tools in this section are intended to raise awareness of the signs and symptoms of stress and taking on the trauma of others give some concrete suggestions for how those in helping professions can help take care of themselves.

Common Causes of Stress in Homeless Services

Job function challenges

- Unrealistic, unclear expectations
- Too much to do and too little time to do it
- Lack of new challenges, too routine
- Lack of input about how to do your job
- Difficulty juggling work, family, other responsibilities

Job security

- Performance evaluation, salary, benefits
- Reorganization of positions, financial cutbacks, layoffs
- Change in job responsibilities or classification

Relations with supervisors and co-workers

- Poor communication or conflicts among staff
- Inadequate support from supervisor or co-workers
- Favoritism, differential treatment, or insensitivity
- Loss of staff or staff turnover

Expectations of how things “should” be

- Clients will want to make changes that you want them to make
- Patients will be grateful
- The agencies we work in will function as a supportive community of helpers
- Workers from other organizations will be cooperative since everybody basically is trying to reach the same goals
- People who work in social services will be above the petty jealousies and gossip that occur in non-service oriented organizations
- You will be appreciated by your supervisors and co-workers
- You will be given sufficient guidance, training and structure to do your job
- Your work will be satisfying most of the time

The risk of caring

- Cost of being empathic, caring, understanding (note that root meaning of word *care* is “to lament, grieve with”)
- Reality of secondary traumatic stress, vicarious trauma, compassion fatigue

Signs and Symptoms of Secondary Traumatic Stress

Do you experience any of the following as a result of your work?

- Social withdrawal
- Low energy, fatigue
- Feelings of being easily overwhelmed
- Pessimistic or cynical outlook on life
- Intrusive work-related thoughts or dreams
- Difficulty keeping appropriate relationship boundaries
- Difficulty setting limits, saying “no”
- Depressed mood
- Lack of motivation
- Increased worry and anxiety
- Emotional numbness
- Feelings that no one understands (or would be able to)
- Loss of interest in sexual activity
- Vague physical aches, pain
- Making poor judgments and decisions
- Feelings of loss of control
- Increased sense of danger or not feeling safe
- Finding your mind wandering at work
- Difficulty making decisions
- Sense of disconnection from loved ones
- Increased feelings of suspiciousness
- Feeling “adrift” spiritually
- Accident-proneness
- Involvement in “risky” activities (e.g. drugs, alcohol, sexual behaviors)
- Increased irritability, agitation
- Feeling “on edge” much of the time
- Feelings of despair
- Wanting to escape, “run away from it all”
- Increased “sick days” from work
- Violating ethical standards
- Reduced work productivity, doing the “bare minimum”
- Decrease in respect for others, increase in blaming
- Increase in obsessive thoughts and/or compulsive behaviors
- Decreased interest in “self-care”

*Adapted from Saakvitne, Pearlman, and Traumatic Stress Institute Staff,
Transforming the Pain: A Workbook on Vicarious Traumatization, 1996.*

Self-Assessment Tool: Self-Care

How often do you do the following? (Rate, using the scale below):

- 5 = Frequently
- 4 = Sometimes
- 3 = Rarely
- 2 = Never
- 1 = It never even occurred to me

Physical Self Care

- Eat regularly (e.g. breakfast & lunch)
- Eat healthfully
- Exercise, or go to the gym
- Lift weights
- Practice martial arts
- Get regular medical care for prevention
- Get medical care when needed
- Take time off when you're sick
- Get massages or other body work
- Do physical activity that is fun for you
- Take time to be sexual
- Get enough sleep
- Wear clothes you like
- Take vacations
- Take day trips, or mini-vacations
- Get away from stressful technology such as pagers, faxes, telephones, e-mail
- Other:

Psychological Self Care

- Make time for self-reflection
- Go to see a psychotherapist or counselor for yourself
- Write in a journal
- Read literature unrelated to work
- Do something at which you are a beginner
- Take a step to decrease stress in your life
- Notice your inner experience - your dreams, thoughts, imagery, feelings
- Let others know different aspects of you
- Engage your intelligence in a new area - go to an art museum, performance, sports event, exhibit, or other cultural event
- Practice receiving from others
- Be curious
- Say no to extra responsibilities sometimes
- Spend time outdoors
- Other:

Continued on next page.

Emotional Self Care

- Spend time with others whose company you enjoy
- Stay in contact with important people in your life
- Treat yourself kindly (supportive inner dialogue or self-talk)
- Feel proud of yourself
- Reread favorite books, review favorite movies
- Identify and seek out comforting activities, objects, people, relationships, places
- Allow yourself to cry
- Find things that make you laugh
- Express your outrage in a constructive way
- Play with children
- Other:

Spiritual Self Care

- Make time for prayer, meditation, reflection
- Spend time in nature
- Participate in a spiritual gathering, community or group
- Be open to inspiration
- Cherish your optimism and hope
- Be aware of nontangible (nonmaterial) aspects of life
- Be open to mystery, to not knowing
- Identify what is meaningful to you and notice its place in your life
- Sing
- Express gratitude
- Celebrate milestones with rituals that are meaningful to you
- Remember and memorialize loved ones who have died
- Nurture others
- Have awe-full experiences
- Contribute to or participate in causes you believe in
- Read inspirational literature
- Listen to inspiring music
- Other:

Workplace/Professional Self Care

- Take time to eat lunch
- Take time to chat with co-workers
- Make time to complete tasks
- Identify projects or tasks that are exciting, growth-promoting, and rewarding
- Set limits with clients and colleagues
- Balance your caseload so no one day is "too much!"
- Arrange your workspace so it is comfortable and comforting
- Get regular supervision or consultation
- Negotiate for your needs
- Have a peer support group
- Other:

*Adapted from Saakvitne, Pearlman, and Traumatic Stress Institute Staff,
Transforming the Pain: A Workbook on Vicarious Traumatization, 1996.*

Finding Resiliency and Renewal in Our Work

“In the event that oxygen masks may be needed, place the mask over your own face before assisting others.”

Providing care to people experiencing homelessness involves working under demanding circumstances, bearing witness to tremendous human suffering, and wrestling with a multitude of agonizing and thorny issues on a daily basis. At the same time, we have the privilege of becoming partners in extraordinary relationships, marveling at the resiliency of the human spirit, and laying claim to small but significant victories. Such is the nature of this work that it can drain and inspire us all at once.

Despite the rewards inherent in the work, it inevitably exacts a personal toll. By listening to others’ stories and providing a sense of deep caring, we walk a difficult path. Yet we do so willingly, knowing that first we must “enter into” another’s suffering before we can offer hope and healing. It is interesting to note that the word *care* finds its roots in the Gothic “kara” which means “lament, mourning, to express sorrow.”

Caring can become burdensome causing us to experience signs and symptoms of what the literature variously calls compassion fatigue, secondary traumatic stress, or vicarious traumatization. The impact is compounded by the frustrations of trying to provide help in the face of multiple barriers to care, including inadequate resources and structural supports for homeless people such as housing, health care, and incomes. To feel weighed down by these circumstances is not unusual or pathological. It is, in fact, a quite normal response.

The “treatment of choice” for diminishing the negative effects of this stress is to seek resiliency and renewal through the practice of healthy self-care. Self-care is most effective when approached with forethought, not as afterthought. In the same manner that we provide care for others, we must care for ourselves by first acknowledging and assessing the realities of our condition, creating a realistic plan of care, and acting upon it. Though many providers practice self-care in creative and effective ways, we all sometimes lose our sense of balance, and fail to provide the necessary care for ourselves with the same resoluteness that we offer care to others.

To better understand what self-care is, here are three things it is *not*:

1) Self-care is *not* an “emergency response plan” to be activated when stress becomes overwhelming. Instead, healthy self-care is an intentional way of living by which our values, attitudes, and actions are integrated into our day-to-day routines. The need for “emergency care” should be an exception to usual practice.

2) Self-care is *not* about acting selfishly. Instead, healthy self-care is about being a worthy steward of the self – body, mind and spirit – with which we’ve been entrusted. It is foolhardy to think we can be providers of care to others without being the recipients of proper nurture and sustenance ourselves.

Continued on next page.

3) Self-care is not about doing more, or adding more tasks to an already overflowing “to do” list. Instead, healthy self-care is as much about “letting go” as it is about taking action. It has to do with taking time to be a human being as well as a human doing. It is about letting go of frenzied schedules, meaningless activities, unhealthy behaviors, and detrimental attitudes such as worry, guilt, being judgmental or unforgiving.

The following A, B, C’s of self-care can provide a useful guide in reflecting upon the status of your own practices and attitudes.

AWARENESS Self-care begins in stillness. By quieting our busy lives and entering into a space of solitude, we can develop an awareness of our own true needs, and then act accordingly. This is the contemplative way of the desert, rather than the constant activity of the city. Thomas Merton suggests that the busyness of our lives can be a form of “violence” that robs us of inner wisdom. Too often we act first without true understanding and then wonder why we feel more burdened, and not relieved. Parker Palmer in *Let Your Life Speak* suggests reflecting on the following question: “Is the life I am living the same as the life that wants to live in me?”

BALANCE Self-care is a balancing act. It includes balancing action and mindfulness. Balance guides decisions about embracing or relinquishing certain activities, behaviors, or attitudes. It also informs the degree to which we give attention to the physical, emotional, psychological, spiritual, and social aspects of our being or, in other words, how much time we spend working, playing, and resting. I once heard it suggested that a helpful prescription for balanced daily living includes eight hours of work, eight hours of play, and eight hours of rest!

CONNECTION Healthy self-care cannot take place solely within oneself. It involves being connected in meaningful ways with others and to something larger. We are decidedly interdependent and social beings. We grow and thrive through our connections that occur in friendships, family, social groups, nature, recreational activities, spiritual practices, therapy, and myriad other ways. Often times, our most renewing connections can be found right in our midst in the workplace, with co-workers and with the individuals to whom we provide care.

There is no formula of course for self-care. Each of our “self-care plans” will be unique and change over time. We must listen well to our own bodies, hearts and minds, as well as to the counsel of trusted friends, as we seek resiliency and renewal in our lives and work.

Fasten your seatbelts and enjoy the ride!

Ken Kraybill

Caring for Your Self, Your Soul, Your Sanity

Self Care (Mind)

To be self “centered” (mindfulness)
Being in charge of your choices, attitudes, and successes
Awareness of the process; strive for progress, not perfection
Self care is a life skill
Interpretation of events is individual and changeable

Healthy Lifestyle (Body)

Sleep, rest and down time help us restore and refresh ourselves
Food is fuel, a way to express our creativity and nurturance
Exercise to move, to feel powerful, to connect with self/others
Body work, breath work, meditation (silence)

Spiritual Care (Spirit)

Imagine slowing down enough to hear your heart speak
Match your values to your actions
Celebrate and savor good moments
Cultivate healthy relationships, find/be a mentor
Let yourself play creatively every day
Practice financial intelligence

Stress and Work (Warning Signs!)

Irritability, negative attitude, gossip, small acts of sabotage
Avoidance, procrastination, “sick” days, fatigue
Anger, anxiety, depression, self-criticism, hypersensitivity
Health problems, sleep difficulties
Drinking, smoking, eating more than you know you should

Strategies for Self Care at Work

Take a break
Practice mindfulness everywhere
Talk it out, be direct and assertive
See a professional (crisis = dangerous “opportunity” for growth)
Remember your choices and your values

Lisa Cunningham Roberts

Mindfulness and Self-care for Shelter Providers

“We have been called to heal the wounds
To unite what has fallen apart
And to bring home
Those who have lost their way.”
Francis of Assisi

Some modest proposals ...

- When you awaken, express gratitude for the new day ... for having a home ... for your health ... friendships ... your work ... for the clients you serve
- Eat a nourishing breakfast
- Offer a gift of hospitality to those you meet throughout the day by “creating a free and friendly space” for them (Henri Nouwen)
- Consider that caring for others is also a way of caring for yourself
- When caught up in a stressful situation ask yourself, “What is the most important thing right now?”
- Practice new ways of seeing – “you can look at a scar and see hurt, or you can look at a scar and see healing.” (Sheri Reynolds)
- Offer yourself to others in your “emptiness” as well as your “fullness”
- Try drinking water or fruit juice instead of carbonated beverages. Monitor your intake of alcohol, caffeine, salt, and sugar.
- Talk out loud (preferably with someone else!) about your daily experiences
- Express appreciation for the work of “support staff” in your organization – receptionists, janitors, data entry, administrators
- Reflect on the root meaning of the word *care* – “to lament, to grieve, to experience sorrow, to cry out with”
- Create a personal mission statement related to your work
- Identify the ways in which your work both depletes and feeds you
- Imagine yourself a biographer when writing chart notes, recording some part of another person’s story
- Before you pick up that ringing phone or dial to make a call ... take a deep, renewing breath

Continued on next page.

- Choose things that inspire you – art, flowers, fresh fruit, sayings, pictures of people– to decorate your workspace (if you have one)
- Invite students from a local massage school to come practice their skills on staff and clients in your work setting
- Start a “wit and wisdom” file
- Do one thing at a time
- Permit yourself time to be silent
- Consider that “a rose withholds its scent from no one ... a tree does not discriminate to whom it provides shade” (Anthony DeMello)
- Be forgiving
- Remember, it’s the little things that count
- Do things outside of work that nurture you. Try out new activities.
- If you feel a little too busy ...stop and take 10 conscious, deep, diaphragmatic breaths
- If you feel moderately busy ... stop and take 20 conscious, deep, diaphragmatic breaths
- If you are excessively busy and feel overwhelmed ... stop and take 30 conscious, deep, diaphragmatic breaths
- After taking deep breaths, pause when finished and feel the energy you have generated
- Create a rhythm of action and contemplation in your workday
- When you go to bed at night, express gratitude for the day you were given ... for having a home ... for your health ... friendships ... for your work ... for the clients you served

Helping Others Cope with Grief and Loss

While self-care is a critical component in staying healthy so that we can provide healing for others, it is equally important to develop sensitivity and skills in helping others deal with grief and loss. These are common themes in the lives of anyone who has been displaced by natural disaster, loss of home, loss of job, loss of family, and loss of identity.

The following resources are intended to provide some simple reminders and suggestions on working effectively with people who are grieving.

Reactions to Loss

When a person experiences a great loss—whether of people, property, jobs, normal routines of life, dreams of what might have been—grief is the normal reaction. Grief includes physical, emotional, intellectual, social and spiritual responses. Some normal adult reactions to loss include:

- Crying, at times uncontrollably
- Tightness in the throat and heaviness in the chest
- Increase or decrease in appetite
- Guilt over unfinished business or personal irresponsibility
- Restlessness; inability to concentrate
- Anger at self, others and God; flying off the handle at seemingly insignificant things
- Aimlessness, forgetfulness, inability to make decisions
- Difficulty sleeping
- Preoccupation with the life of the lost loved one
- Sense of a deceased loved one's presence
- Need to “tell their story” over and over
- Attempting to protect others by denying grief reactions
- Increase or decrease in communication
- Role confusion in families
- Isolation or overprotection of certain family members
- Obsessive attachment to “linking objects” that may be the only thing remaining of the lost person or place
- Sadness, depression, loss of joy
- Distancing from family and friends

Linda Olivet

Keys to Understanding and Accepting The Grieving Process

- The process of grieving is a natural outcome of experiencing a significant loss.
- Grief is a natural healing process. Trying to avoid it is counterproductive.
- The ways we have dealt with previous crises will affect current and future reactions.
- Loss of a significant attachment is a threat to all significant attachments.
- We cannot take in a major loss all at one time.
- We don't "get over" it, but we can move on.
- Facing our greatest fears can be liberating.
- Grief is a holistic process and affects all aspects of our lives.
- Men and women are likely to have different strengths and vulnerabilities in the process of grieving.
- Grief ebbs and flows. There is no predictable pattern or timeline that it follows.

Adapted from: Schneider, John M. (1994). Finding My Way: Healing and Transformation Through Loss and Grief. Colfax, VT: Seasons Press.

Some Suggestions to Help Grieving People

Be sensitive and compassionate when someone starts to talk about the loss. If you cannot talk with them at that moment, ask someone else to be with them and return later to continue the conversation yourself.

Provide a quiet, private place, if possible, when the person needs to cry, express frustrations or anger; encourage the “telling of the story” of what has happened.

Help find a special container for “linking objects”—pictures, jewelry, household items, etc—so that they can easily be found during shelter life and afterwards.

Plan a candlelight memorial service as appropriate.

Make shelter rounds daily to check on people’s needs and changing responses.

Provide sympathy and comfort through a smile, a hug, and a listening ear.

Avoid trying to smooth over the loss with platitudes and explanations. Listen without judging the grief reactions you are seeing.

Identify ministers, counselors, and other helpers for those who might benefit from their assistance.

Listen attentively to concerns and do specific things to help such as finding relatives, getting information about the conditions at their home as soon as possible, getting information about lost loved ones, care of bodies, etc.

Assist with care of children while the adults are getting information and gathering their wits about them to convey bad news to the younger members of their families.

Be a companion with someone in grief. You do not have to be a therapist, minister, or counselor to provide help. Just “being with” someone is a great gift.

Remember to be sensitive to the loss of pets.

Acknowledge how painful loss experiences must be, but avoid sharing your own stories of loss and grief. Keep the focus on the grieving person’s story.

Linda Olivet

Recovering from the Aftermath of a Disaster: How to Cope and What Works

FOR YOURSELF

Take care of your body

Maintain a good diet, get enough sleep, stay physically active.

Share your stress and grief

Talk with others about how you are feeling about what has happened and what you face.

Recognize your limits

Don't overwork yourself. Take time for relaxation and recreation.

Prioritize your time

Write down what needs to be done and in what order.

Avoid alcohol and drugs

They will not help in the long run and will likely cause other problems.

Connect with your family and friends, and community

Don't allow yourself to become isolated. Seek out and maintain connections with your community, friends, relatives, neighbors, co-workers, and church members.

FOR YOUR FAMILY

Keep some sense of order and normalcy

Keep routines in place such as family meals, certain enjoyable activities, other family rituals.

Tend to your relationship as a couple

Take time to be alone, talk about how you are feeling, have fun together.

Talk with your children about their experience

Listen to what they have to say, let them freely express their feelings. This is a confusing and frightening time. Remember that children do not have the same level of understanding or coping that you have.

Adapted from pamphlet Recovering from the Emotional Aftermath of a Disaster:
Information for You and Your Family, *Katrina Crisis Counseling Program, Houston, TX*

Shelter Health:
Essentials of Care for People Living in Shelter

Communication and Connection

Learning Goal:

- To enhance outreach and engagement skills.

This guide includes many concrete suggestions for ensuring a safe and healthy shelter environment that is sensitive to physical and mental health issues. As important as any of the other tools this guide and its accompanying materials may provide is the material included in the following section—material that focuses on interpersonal communication skills.

Anyone who has worked in homeless services, mental health, or primary care for any length of time knows that the foundation for any therapeutic intervention is a human connection rooted in deep listening. The same is true for the provision of emergency services such as shelter. It is not enough simply to meet the basic needs. Emergency service providers are also in the unique position to be able to make a strong connection with the people served, and use that connection to address a range of issues to improve the long-term stability of shelter residents.



That therapeutic connection does not happen accidentally. It only happens through a commitment to effective, compassionate communication. This section of the guide will present some basic communication skills that can be utilized by staff and volunteers regardless of role or position.

The material that follows also explores frameworks of engagement and tools for effective outreach that have been honed by the Health Care for the Homeless approach to care over the past 20 years. These approaches will be of use to shelter providers in thinking about reaching out to and connecting with people not only “out there” in the community, but also within the walls of the shelter.

The Tool Kits

At the beginning of each section of this Guide, readers will find lists that outline the contents of the Tool Kits that can be found in electronic form on the CD that accompanies this Guide. While some of the tools and handouts are found both in the Guide and in the Tool Kits, most of the items listed below are only found in the Tool Kits. They are to be used to supplement the material in the Guide and to provide shelter providers with day-to-day tools for use in the shelters.

Tool Kit F: Communication and Connection

- F-1 Basics of Good Communication Skills
- F-2 Listening Well
- F-3 Six Habits of Highly Ineffective Listeners
- F-4 Cultural Competence Checklist
- F-5 Chinese Folk Tale

Common Human Needs: The Basis for Outreach

Outreach and engagement are two concepts that are deep in the consciousness of those who provide health care for people experiencing homelessness. Those providers know that any therapeutic work that happens—any healing at all—emanates from the basic human connection that happens between “doctor and patient” or “therapist and client” or “shelter volunteer and resident.”

The foundation of helping work is to be able to connect well with the person sitting there in your office, shelter, or on a street corner.

So when we use the term *outreach*, don't only think about teams of people hitting the street with backpacks full of supplies or driving around in mobile health clinics pulling up in parking lots. Picture also “working the waiting room or the floor of the shelter,” seeking ways to connect with people, recognize their needs, and lay the foundation for healing.

Likewise, *engagement* should not be viewed as a technical concept for use only by those who have clinical training. It is what we all do when we meet people where they are and offer them some support, solutions, or kindnesses that help in that moment.

Seven Human Needs

To be treated as an individual

To express feelings

To receive empathic responses

To be recognized as a person of worth

To not be judged

To make one's own choices and decisions

To keep secrets about oneself

Adapted from Biestek, F.P. The Casework Relationship, 1957

Frameworks of Engagement

Story

Everyone has a story. Sharing our stories creates a common ground on which we can meet each other as human beings. Our stories are neither “right nor wrong.” They are simply our stories. Some of us can tell our stories with an unclouded memory for our past, clarity about our present situation, and a realistic understanding of where our journey is heading in life.

Some of us find telling our story extremely difficult. Our past may be painful and deeply hidden from memory. We may never have had much support in putting together any real, coherent sense of ourselves in relationship to others. Current stresses in life may be upsetting or confusing the sense of who I am, where I have been, and where I am going.

Mental illness, intoxication, neurological disorders, developmental disorders, and brain injuries can deprive a person of the capacity to tell their story and locate themselves with others and the world. In the midst of illness a person’s story may take on disjointed or bizarre dimensions. Difficulty in sharing a coherent story may be an indication of disability, and a need for a patient, especially careful approach to working together.

Inviting another to share their story can be a non-threatening way to gain mutual trust, and develop a picture of a person’s situation and needs. A willingness to share a little of our own story in the conversation helps build the common ground. We end, in a sense where we began. As we share our stories over time, hopefully we are both enriched. At best, I have been able to add a little something to another’s story, some hope, some concrete help, some encouragement, and they have added something of their courage, their humanness, and their experience to my story.

Craig Rennebohm

Hospitality – Creating Space for the Stranger

A feeling of estrangement, of not belonging, is common to the experience of homelessness. One becomes separated from ordinary activities, relationships, and a sense of place and purpose in the world. Literally, one becomes a stranger. The longer homelessness persists, the more deeply ingrained this experience of disaffiliation becomes.

"Offering the gift of hospitality" is an antidote to this estrangement. In his book *Reaching Out*, Henri Nouwen defines hospitality as "creating free and friendly space for the stranger." As such, it is an invitation to relationship. A hospitable relationship provides a welcoming face and presence, and creates an interpersonal refuge from an often impersonal, hostile world. Thus, a person in the midst of homelessness can experience a bit of being "at home" in the context of a safe, friendly relationship.

Hospitality is offered with no strings attached. It does not pass judgment or make demands. Instead, it provides space in which the other can freely explore personal needs, concerns, capabilities and hopes. It allows for self-reflection and restoration. It instills and renews hope. Such a relationship provides both a "resting place" and a "guiding light." The power of hospitality lies not in coercion but in listening reflectively, sharing information and ideas, and in the art of gentle persuasion. It is founded upon the trustworthiness, competency and integrity of the provider.

When we think of our own experiences of being graced with the hospitable presence of another, we remember it as calming, orienting and renewing. It allows us to remember who we are – returning to our true home – so that we can move ahead more confidently in our lives. The absence of such a presence often leads to isolation, disorientation, confusion and despair.

Hospitality can be offered in many ways – a simple gesture of acknowledgement, a warm smile, a cup of coffee, by listening patiently without interrupting, offering information, a word of encouragement, or simply by being present with the other person in silence. Hospitality cannot be rushed. It requires time, patience and kindly persistence. It sees the "bigger picture" rather than seeks the "quick fix."

As trust within the relationship builds, a sense of companionship develops. Time is spent together on a more predictable basis. Basic needs are addressed. The homeless individual shares more and more of his or her story. Small tasks are shared. Inquiries are made about other resources. In time, hospitality leads to increasing the "circle of care" to help the individual access needed resources and services. In this manner, health care, housing, financial and other treatment and social service needs are met.

Over time, as the individual progresses towards greater stability, the relationship reflects a growing sense of mutuality. It is not just one-sided. Once a stranger, this person becomes known as neighbor and friend. We discover that our stories are interwoven and that we are bonded by our common humanity. In this mutuality, each person is recognized for the strengths and gifts that they bring to the relationship as well as to the larger community. In the end, hospitality that is given becomes hospitality received.

Ken Kraybill

Care

What does it mean to care? The word care has become a very ambivalent word. When someone says: "I will take care of him!" it is more likely an announcement of an impending attack than of tender compassion. And besides this ambivalence, the word care is most often used in a negative way. "Do you want coffee or tea?" "I don't care." "Do you want to stay home or go to a movie?" "I don't care." This expression of indifference toward choices in life has become commonplace. And often it seems that not to care has become more acceptable than to care, and a carefree life-style more attractive than a careful one.

Real care is not ambiguous. Real care excludes indifference and is the opposite of apathy. The word "care" finds its roots in the Gothic "Kara" which means lament. The basic meaning of care is: to grieve, to experience sorrow, to cry out with. I am very much struck by this background of the word care because we tend to look at caring as an attitude of the strong toward the weak, of the powerful toward the powerless, of the haves toward the have-nots. And, in fact we feel quite uncomfortable with an invitation to enter into someone's pain before doing something about it.

Still, when we honestly ask ourselves which persons in our lives mean the most to us, we often find that it is those who, instead of giving much advice, solutions, or cures, have chosen rather to share our pain and touch our wounds with a gentle and tender hand. The friend who can be silent with us in a moment of despair or confusion, who can stay with us in an hour of grief and bereavement, who can tolerate not knowing, not curing, not healing and face with us the reality of our powerlessness, that is the friend who cares.

To care means first of all to be present to each other. From experience you know that those who care for you become present to you. When they listen, they listen to you. When they speak, you know they speak to you. And when they ask questions, you know it is for your sake and not for their own. Their presence is a healing presence because they accept you on your terms, and they encourage you to take your own life seriously and to trust your own vocation.

Our tendency is to run away from the painful realities or to try to change them as soon as possible. But cure without care makes us into rulers, controllers, manipulators, and prevents a real community from taking shape. Cure without care makes us preoccupied with quick changes, impatient and unwilling to share each other's burden. And so cure can often become offending instead of liberating.

Henri Nouwen
Excerpted from Out of Solitude

Purpose and Principles of Outreach

Purpose

“...contact with any individual who would otherwise be ignored (or underserved) ...in non-traditional settings for the purpose of improving their mental health, health, or social functioning or increasing their human service and resource utilization.”

Morse, Gary. Conceptual Overview of Mobile Outreach for Persons who are Homeless and Mentally Ill, presented at APHA annual meeting in New Orleans, LA, 1987

Principles

- Friendly, non-threatening approach
- Services taken to individuals rather than waiting for them to come to the services
- Repeated contact over time
- Engagement of those who are reluctant or suspicious to receive help
- Prompt response to client’s basic survival needs
- Client’s overall needs assessed, services and strategies tailored to meet those unique needs
- Flexibility in the menu of services offered
- Patience in motivating clients to accept services
- Variable times for client contact, including non-scheduled contacts
- Team approach to outreach

Adapted from Marsha McMurray-Avila in Organizing Health Services for Homeless People, 2001

Where Outreach Happens

Fixed site outreach occurs where programs have “set up shop” in a location where homeless people gather. **Mobile outreach** moves around to anywhere homeless people might be found.

Fixed-site

Scheduled clinics in or near:

- shelters, missions
- drop-in centers
- transitional housing
- respite programs
- soup kitchens
- hygiene facilities
- other homeless facilities

Mobile

Street locations:

- city streets, alleys
- bridges and overpasses
- subways
- parks, beaches
- vacant lots, abandoned buildings
- vehicles

Rural areas:

- “doubled up”
- along roads, vehicles
- wooded areas, riverbanks
- foothills, desert areas
- barns, garages
- camps, designated camping areas

Public facilities:

- libraries
- bus or train stations
- airports
- racetracks
- cafeterias, coffee shops

Institutions (to make contact with ongoing or potential clients)

- hospitals
- jails, prisons
- detox facilities, treatment programs
- some hotels/motels/SRO’s
- public welfare agencies

Adapted from Marsha McMurray-Avila in Organizing Health Services for Homeless People, 2001

Services Provided Through Outreach and Case Management

Engagement

- Create a safe “presence” – make non-verbal contact
- Initiate non-threatening conversation
- Offer sandwiches and coffee
- Offer a blanket, sleeping bag, hat, socks
- Offer sunscreen, condoms, hygiene articles

Information and Referral

- Provide information about available services
- Facilitate effective referrals
- Accompany individual as needed

Direct Services

- Assist with accessing shelter/housing, entitlements, ID, legal assistance
- Assist client in utilizing services linked to particular site – food, clothing, showers, laundry, phone, mail, etc.
- Assess a client’s medical, psychiatric and social needs and develop a treatment plan
- Provide direct medical care, mental health or chemical dependency services
- Screen for specific illnesses or disorders
- Make referrals to specialty care, dental care, mental health services, chemical dependency treatment, or other services not provided by HCH
- Provide case management
- Advocate with other agencies for client to receive necessary services
- Enhance motivation
- Facilitate support groups, life-skills training
- Provide health education/promotion
- Intervene in crisis situations making links to emergency medical, detox or psychiatric care

Adapted from Marsha McMurray-Avila in Organizing Health Services for Homeless People, 2001

Good Communication

The concept of “OARS” presented in the following pages is taken from the practice of Motivational Interviewing, developed by William Miller and Stephen Rollnick in the context of substance use treatment. The skills used in this approach are helpful in any work with people in crisis. There are some basic underlying concepts that guide this approach:

- Every person has within themselves the capacity to change
- No one can make anyone do anything, but we can work to enhance someone else’s motivation to change

The following basic communication tools can work well in brief interventions as well as in longer, more in-depth encounters with people.

QARS: Open Questions

Open questions encourage people to talk about whatever is important to them. They help to establish rapport, gather information, and increase understanding. Open questions are the opposite of closed questions that typically elicit a limited response such as yes or no.

Open questions invite others to “tell their story” in their own words without leading them in a specific direction. Open questions should be used often in conversation but not exclusively. Of course, when asking open questions, you must be willing to listen to the person’s response.

To contrast open vs. closed questions, consider the following examples. Note how the topic is the same in both questions, but the likely responses will be very different.

- Did you have a good relationship with your parents?
- What can you tell me about your relationship with your parents?

Examples of open questions:

- How are things going with you?
- Would you tell me more about that?
- What are the good things for you about drinking?
- When would you be most likely to share needles with others?
- What do you think you might lose if you decided to get treatment?
- What might be gained?
- What have you tried before to make a change?
- How would you like things to be different?
- What do you want to do next?

*Adapted from motivational interviewing materials by David B. Rosengren, Ph.D.
and from Miller and Rollnick, Motivational Interviewing, 2nd edition, 2002*

OARS: Affirmations

Affirmations are statements and gestures that recognize client strengths and acknowledge behaviors that lead in the direction of positive change, no matter how big or small. Affirmations build confidence in one's ability to change. To be effective, affirmations must be genuine and congruent.

Examples of affirming responses:

- I appreciate that you are willing to meet with me today.
- You are a very resourceful person.
- You've been through a lot.
- You handled yourself really well in that situation.
- That's a good suggestion.
- I think you are on the right track.
- Thank you for sharing that information with me.
- I've enjoyed talking with you.

*Adapted from motivational interviewing materials by David B. Rosengren, Ph.D.
and from Miller and Rollnick, Motivational Interviewing, 2nd edition, 2002*

The Use of Encouragement

Another way to talk about affirmations is "giving encouragement." Providing encouragement, in its various forms, is a simple but powerful way to support others to make positive change steps, and subsequently to help them internalize the benefits of the steps they have taken.

Elements of effective encouragement include:

- Regarding the individual as having intrinsic value
- Showing faith in the person's ability to succeed
- Recognizing one's efforts towards positive change
- Encouraging the individual to take risks
- Supporting development of effective skills
- Recognizing and focusing on the person's strengths

Adapted from Job Corps Technical Assistance Guide D, March 2003

OARS: Reflective Listening

"People only listen when they feel listened to."

Carl Rogers

Reflective listening is central to communicating effectively. It is the pathway for engaging others in relationship, building trust, and fostering motivation to change. Reflective listening appears deceptively easy, but it takes hard work and skill to do well. Sometimes the “skills” we use in working with clients do not exemplify reflective listening but instead serve as roadblocks to effective communication. Examples include misinterpreting what is said or assuming what a person needs.

It is vital to learn to *think* reflectively. This is a way of thinking that accompanies good reflective listening that includes interest in what the person has to say and respect for the person's inner wisdom. Its key element is a hypothesis testing approach to listening. What you think the person means may not be what they really mean. Listening breakdowns occur in any of three places:

- **Speaker does not say what is meant**
- **Listener does not hear correctly**
- **Listener gives a different interpretation to what the words mean**

Reflective listening is meant to close the loop in communication to ensure breakdowns don't occur. The listener's voice turns down at the end of a reflective listening statement. This may feel presumptuous, yet it leads to clarification and greater exploration, whereas questions tend to interrupt the client's flow. Some people find it helpful to use some standard phrases:

- **“So you feel...”**
- **“It sounds like you...”**
- **“You're wondering if...”**

There are three basic levels of reflective listening that may deepen or increase the intimacy and thereby change the affective tone of an interaction. In general, the depth should match the situation. Examples of the three levels include:

Repeating or rephrasing – listener repeats or substitutes synonyms or phrases; stays close to what the speaker has said

Paraphrasing – listener makes a major restatement in which the speaker's meaning is inferred

Reflection of feeling – listener emphasizes emotional aspects of communication through feeling statements – deepest form of listening

Varying the levels of reflection is effective in listening. Also, at times there are benefits to over-stating or under-stating a reflection. An overstatement (i.e. an amplified reflection) may cause a person to back away from a position while an understatement may lead to the feeling intensity continuing and deepening.

*Adapted from motivational interviewing materials by David B. Rosengren, Ph.D.
and from Miller and Rollnick, Motivational Interviewing, 2nd edition, 2002*

OARS: Summaries

Summaries are special applications of reflective listening. They can be used throughout a conversation but are particularly helpful at transition points, for example, after the person has spoken about a particular topic, has recounted a personal experience, or when the encounter is nearing an end.

Summarizing helps to ensure that there is clear communication between the speaker and listener. Also, it can provide a stepping stone towards change by accentuating the statements a person makes suggesting they are thinking about changing.

Structure of Summaries

- 1) Begin with a statement indicating you are making a summary. For example:
 - Let me see if I understand so far ...
 - Here is what I've heard. Tell me if I've missed anything.
- 2) Give special attention to Change Statements. These are statements made by the client that point towards a willingness to change. Miller and Rollnick have identified four types of change statements, all of which overlap significantly:
 - Problem recognition: "My use has gotten a little out of hand at times."
 - Concern: "If I don't stop, something bad is going to happen."
 - Intent to change: "I'm going to do something, I'm just not sure what it is yet."
 - Optimism: "I know I can get a handle on this problem."
- 3) If the person expresses ambivalence, it is useful to include both sides in the summary statement. For example: "On the one hand ..., on the other hand ..."
- 4) It is legitimate to include information in summary statements from other sources (e.g. your own clinical knowledge, research, courts, family).
- 5) Be concise.
- 6) End with an invitation. For example:
 - Did I miss anything?
 - If that's accurate, what other points are there to consider?
 - Anything you want to add or correct?
- 7) Depending on the response of the client to your summary statement, it may lead naturally to planning for or taking concrete steps towards the change goal.

*Adapted from motivational interviewing materials by David B. Rosengren, Ph.D.
and from Miller and Rollnick, Motivational Interviewing, 2nd edition, 2002*

Creating a Listening Environment

Helping Shelter Residents Regain Their Voices

Homeless people have little control over virtually every aspect of their lives. Their choices are severely limited. Hope is tenuous. The experience of homelessness leaves them feeling vulnerable and powerless. Anxiety and fear persist about meeting basic needs in the present, and what the future might hold. In this context, it is critically important for staff to create a shelter environment in which residents' voices are readily heard as a means to help them regain a sense of control over their lives. Below are some recommendations to consider.

- **Make an agency-wide commitment to listening** to residents and soliciting their ideas – build this expectation into the agency's mission statement, organizational structure, and policies.
- **Emphasize a collaborative approach in how staff communicate and work with shelter residents.** Discourage directive, top-down approaches. Incorporate the spirit and language of collaboration into job descriptions, staff orientation and training, and supervision.
- Maintain an **open door policy** for communicating with shelter residents.
- **Hold focus groups** regularly to listen to the concerns, ideas and hopes of residents.
- Place a **solution box** (instead of a suggestion box) in the shelter. Submissions should include the person's name. Whether or not it is implemented, acknowledge the resident who submitted the idea.
- **Involve shelter residents in the shelter's board**, advisory committee, or subcommittees to include their voices in program policies, practices, evaluation and planning.
- **Set aside time at each staff meeting** and board/advisory committee meeting to discuss the "state of the shelter" – the general tone of the shelter environment, what residents are saying, what's working, and what needs to be improved.
- **Invite residents to help** define and address the larger structural and systemic issues that impact them and about which the agency intends to advocate for change.
- **Encourage residents to become involved** in the efforts of other community organizations and groups addressing poverty and homelessness. This might include civic and faith-based organizations, boards, committees, work groups, and coalitions.
- **Involve residents** in response networks for telephone calls, faxes, and letter-writing campaigns.

Ken Kraybill

Sustaining Community Dialogue and Response

Learning Goal:

- To foster collaboration by bringing together community members to provide optimal care for people living in shelter.

The days immediately following Hurricane Katrina in the late summer of 2005 were witness to profound breakdowns in collaborative disaster response on the one hand, and solid community planning on the other. The immediate response in many communities was slow and confused, while other communities stepped in quickly to provide shelter, housing, and health services to evacuees. It has become clear in the weeks and months following this immense disaster that sustained community dialogue and coordinated response are essential to prevent the breakdowns that happened in August and September of 2005.

Similar patterns are evident in how communities respond to the crisis of homelessness. Some communities have worked extensively to bring together policy makers, service providers, faith communities, philanthropic interests, and others to enhance collaboration, while others have continued to remain somewhat fragmented, meeting immediate needs with un-coordinated, temporary solutions.

Rather than presenting didactic information with recommendations on how to proceed with coordinated efforts, this portion of the guide (and the related trainings) attempts to lay out a framework to begin or expand ongoing community dialogue. Each community must map its own course, but there are some “best practices” that open up the possibility of effective, collaborative response to serving people who find themselves living in shelter.

The Tool Kits

At the beginning of each section of this Guide, readers will find lists that outline the contents of the Tool Kits that can be found in electronic form on the CD that accompanies this Guide. While some of the tools and handouts are found both in the Guide and in the Tool Kits, most of the items listed below are only found in the Tool Kits. They are to be used to supplement the material in the Guide and to provide shelter providers with day-to-day tools for use in the shelters.

Tool Kit G: Sustaining Community Dialogue and Response

- G-1 Checklist for Making Successful Referrals
- G-2 Norfolk Shelter Standards
- G-3 Ohio Basic Shelter Standards
- G-4 Seattle Guidelines
- G-5 Toronto Shelter Guiding Principles
- G-6 “Healing Hands” August 2004: Disaster Planning

Working Effectively in the Community

- Through your attitude, actions and words, serve as an “ambassador” for homeless and displaced people in all your encounters with others in the community.
- Promote a spirit of collaboration with shopkeepers, police, clergy, and “natural helpers” in the neighborhood. They are valuable “eyes and ears” to assist you in your outreach efforts.
- Develop and maintain a strong working relationship with at least one staff person from key social service organizations.
- Offer to provide education and training for other organizations about issues related to homelessness. Likewise, invite them to provide relevant training for your team/organization.
- Consider setting up an inter-agency consortium to meet training needs. Each participating agency hosts and provides a workshop on a rotating basis. A representative planning group chooses topics.
- Go out on outreach “rounds” at selected agencies on a scheduled basis. This provides an opportunity to maintain regular contact with agency personnel, to accept referrals, make follow-up contacts, and provide consultation.
- Participate in developing formal interagency agreements to address issues specific to the care of homeless people. For example, ways to expedite referrals, homeless-specific admission criteria, discharge planning, and sharing of information.
- Provide advocacy on behalf of other community programs that are part of the larger network of services for homeless people.
- Invite others to open houses, celebrations, farewells, fundraisers, and other special occasions. Attend other agencies’ functions.
- Make a special effort to reach out to organizations “on the fringes” of the human services community.

Checklist for Making Successful Referrals

- I have an adequate understanding of the client's situation and perceived needs.
- The client and I have talked about how to prioritize these needs and what options exist to help address them.
- He or she is willing and ready to be referred.
- "We have discussed what issues might make it difficult for him or her to follow through with the referral."
- I am familiar with the agency to which I am referring the individual, including its cultural appropriateness, eligibility requirements and services.
- The agency has the *capacity* and *willingness* to serve people experiencing homelessness in a knowledgeable and respectful manner.
- I have a working relationship with at least one staff person at this agency who can provide useful information and help advocate for the client.
- I have considered whether or not to accompany the client based on the individual's:
 - Ability to negotiate complex social situations
 - Ability to provide and receive information
 - Ability to tolerate waiting
 - Level of ambivalence about seeking help
 - Interpersonal style (passive to argumentative)
- If the person is going alone, I have provided sufficient information and "coaching" to help make the referral successful.
- I have made a plan to follow up with the client to see how things went and to determine next steps.
- I have a backup plan if this referral fails to work out for any reason.

Everyone Hates Meetings

Meetings are not the only place where good community collaboration happens, but sitting together at the same table and approaching a problem together as a community is critically important to sustaining community dialogue.

The main reason that many people can't stand meetings is that most meetings are badly run, dominated by a few vocal, opinionated people, and feel like a waste of time to the majority of the people around the table. On the following pages are some suggestions for making meetings more effective. These can be applied to coalition meetings, organizational staff meetings, sessions of consumer advisory boards, or any other meeting of which you are a part. Use them well.

Meetings Stink...5 Tips For Making Yours Useful

By David Batstone

I don't feel the need to persuade you that most meetings stink. I am confident that you have passed enough wasted hours in a meeting room to know that painful truth. Sadly, just last week I spent two hours in a confabulation that should have taken 20 minutes.

I am in the business of making simple what are complex issues. In that tradition, I have pinpointed two reasons why meetings stink: A) the convener does not know how to run a useful meeting; B) the convener likes being the convener so he milks the attention for all its worth.

Assuming that you do not fit in Category B - in which case you do not need to read further...instead go call a therapist - I offer some tried and useful tips for running a useful meeting.

1) Know the purpose of the meeting. As you prepare an agenda, jot down what you actually need to accomplish, especially the decisions that need to be made. If you don't have time to prepare for the meeting, you don't have time to convene it at all. Postpone the meeting until you are ready to make it useful. The regularly scheduled weekly meeting is particularly vulnerable to this booby trap. We often hold meetings simply because they are on the calendar, whether they are needed or not.

2) Don't use the occasion to grind an axe. If you are having a problem with someone in your organization, don't use the meeting as the venue for your frustration. It's the coward's way out, most tempting because we feel safer in a group. Confront the target of your disappointment directly; don't punish the gathered assembly.

3) Settle for nothing less than concise and focused participation. Announce politely at the beginning of the meeting that you value the time of all the members of the group. For that reason, you will intervene when comments are off point, long-winded, or unintelligible. For every one person you offend by the interruption, you will win a room full of grateful admirers.

4) Power corrupts; PowerPoint corrupts absolutely. Don't get me wrong, a PowerPoint can be an effective way to deliver content. All too often, however, people cannot resist the compulsion to add in unnecessary charts and data into their technical presentations. In my experience, it takes presenters twice as long on average to reach their final points using a PowerPoint as it would if they expressed them verbally. For that reason, if someone plans to present a PowerPoint in a meeting that I am chairing, I ask them to submit a copy to me in advance of the meeting so that I can review it. I am not afraid to give them editorial feedback how to slice and dice in order to save on meeting time.

Continued on next page.

5) Set a time limit and stick to it. Better yet, finish early. A friend offered me an insight years ago when my fiancée and I were planning our wedding, and it's stuck with me. She said, "No matter how much time you set aside for preparing your wedding, it will eat up every moment." Meetings have that same elastic quality; they will fill up whatever space that you make for them, and then some. Give each item of business its appropriate time in a meeting, and no more. Finishing a meeting early is not a crime!

Wisdom dictates that you project the pace of each agenda item before the meeting begins. If an item of business unexpectedly mushrooms into a major dilemma, wall it off for later problem-solving outside the meeting. If the dilemma is mission-critical, on the other hand, jettison other agenda items that are inconsequential. Only in exceptional circumstances should you willy-nilly decide to go overtime. Treat everyone's time as valuable, and they will respect you for that attitude.

As strange as it may sound, I cannot ever recall a senior manager suggesting to me that his or her people waste too much time in inefficient meetings. But truth be known, few work practices eat away at the productivity of an organization.

http://www.rightreality.com/recent_articles.html

Ten Tips for Effective Meetings

By Steve Kaye

- 1) Avoid meetings.** Test the importance of a meeting by asking, "What happens without it?" If your answer is, "Nothing," then don't call the meeting.
- 2) Prepare goals.** These are the results you want to obtain by the end of the meeting. Write out your goals before the meetings. They should be so clear, complete, and specific that someone else could use them to lead your meeting. Also, make sure they can be achieved with available people, resources, and time. Specific goals help everyone move efficiently towards relevant results.
- 3) Challenge each goal.** Ask, "Is there another way to achieve this?" For example, if you want to distribute information, you may find it more efficient to phone, FAX, mail, e-mail, or visit. Realize that a meeting is a team activity. Save tasks that require a team effort for your meetings.
- 4) Prepare an agenda.** Everyone knows an agenda leads to an effective meeting. Yet, many people "save time" by neglecting to prepare an agenda. A meeting without an agenda is like a journey without a map. It is guaranteed to take longer and produce fewer results. Note, without an agenda, you risk becoming someone else's helper (see tip #6 below).
- 5) Inform others.** Send the agenda before the meeting. That helps others prepare to work with you in the meeting. Unprepared participants waste your time by preparing for the meeting during the meeting.
- 6) Assume control.** If you find yourself in a meeting without an agenda walk out. If you must stay, prepare an agenda in the meeting. Collect a list of issues, identify the most important, and work on that. When you finish, if time remains, select the next most important issue. Note: you can use a meeting without an agenda to recruit help for your projects.
- 7) Focus on the issue.** Avoid stories, jokes, and unrelated issues. Although entertaining, these waste time, distract focus, and mislead others. Save the fun for social occasions where it will be appreciated.
- 8) Be selective.** Invite only those who can contribute to achieving your goals for the meeting. Crowds of observers and supporters bog down progress in a meeting.
- 9) Budget time.** No one would spend \$1000 on a 10¢ pencil, but they often spend 40 employee hours on trivia. Budget time in proportion to the value of the issue. For example, you could say, "I want a decision on this in 10 minutes. That means we'll evaluate it for the next 9 minutes, followed by a vote."
- 10) Use structured activities in your meetings.** These process tools keep you in control while you ensure equitable participation and systematic progress toward results.

http://www.morebusiness.com/running_your_business/management/Estory-23896.brc

Guiding Principles and Shelter Standards

Many communities have agreed upon guiding principles and minimum standards to guide the operation of all shelters in the area. The community dialogues out of which such principles and standards emanate can be extremely helpful in fostering community collaboration and planning, both of which ultimately create higher quality care for all those who access services.

We strongly encourage all communities to develop a process to establish guiding principles and standards of care that will ensure effective, respectful, client-centered shelter services.

Following are some examples of how communities have shaped these guidelines. Please use these as a starting point for community dialogue, or as samples which can be adapted to meet specific community concerns.

Toronto Shelter Standards Guiding Principles

The Shelter Standards are grounded in the following principles and values that promote a philosophy for service provision. These principles and values are not shelter standards, but rather help guide the delivery of shelter services.

1. All homeless persons have the right to shelter service regardless of political or religious beliefs, ethno-cultural background, (dis)ability, gender identity and/or sexual orientation. Staff must respect and be sensitive to the diversity of residents. Discriminatory and racist incidents or behaviors are not tolerated.
2. The shelter will provide an atmosphere of dignity and respect for all shelter residents, and provide services in a non-judgmental manner.
3. Residents are capable of moving toward increasing levels of self-reliance and self-determination. Shelter staff will work with residents to assist them in achieving their goals.
4. Shelters will be sensitive to the ethno-specific and linguistic needs of residents. Staff will work to ensure residents have access to culturally appropriate interpreter services and that written materials are available in other languages.
5. Gender identity is self-defined. Sometimes this may not correspond with a person's physical appearance. Service providers need to accept gender identity as defined by the individual rather than by the perception of staff and/or other residents.
6. Shelter staff often have access to detailed and highly sensitive personal information about residents. Protecting the privacy and confidentiality of shelter residents and their personal information is of the utmost importance.
7. All people staying in shelters will have access to safe, nutritious and culturally appropriate food.
8. The health and safety of residents, volunteers and staff is of the highest importance in each shelter. Training, policies, procedures and regular maintenance are intended to encourage, improve and maintain the health and safety of all people residing, volunteering and working in the shelter.
9. People who are homeless have few resources and the shelter system is often their final option to receive the basic necessities of life: food and shelter. Issuing service restrictions in the shelter system must be done only as a last resort and in the most serious cases.

Continued on next page.

10. People who are homeless, like other members of our community, may use substances to varying degrees. Everyone is entitled to shelter service whether or not they use substances. As a result, admission, discharge and service restriction policies must not be based on substance use alone, except for those shelters operating on an abstinence basis. To increase the accessibility of the shelter system and to respond to diverse resident needs, a range of service approaches from abstinence to harm reduction must be available within the shelter system.

11. In order to provide effective shelter programs and services, shelter residents must be involved in service provision, program planning, development and evaluation, and policy development.

12. Shelters that include children and youth must provide supports and activities and ensure that the school-related, recreation and treatment needs of resident children are met on-site or through referral to community-based services.

13. The shelter should offer an opportunity for children and youth with developmental and/or physical disabilities to develop their full potential within an environment where they can interact and socialize with other children.

14. Shelters are part of a larger network of homeless services and agencies. Collaboration within this network is important to ensure effective and coordinated services.

Excerpted from Toronto Shelter Standards www.toronto.ca/housing/pdf/shelter_standards.pdf

Ohio Basic Standards for Emergency Homeless Shelters

ADMINISTRATION

1. The shelter shall be operated by a non-profit organization, recognized under section 501(c)(3) of the Internal Revenue Code.
2. The shelter shall not require clients to participate in religious services or other forms of religious expression.
3. The shelter shall not discriminate on the basis of race, religion, or national origin. Shelters serving families with children shall also not discriminate on the basis of the sex or age of the children or the size of the family, except where limited by the facility.
4. The shelter's Board of Directors shall consist of voluntary (unpaid) members, with the possible exception of the agency's CEO or Director.
5. The shelter's Board of Directors shall meet at least on a quarterly basis and set overall policy for the shelter.
6. The shelter shall have a secure storage space for confidential documents relating to clients and personnel.
7. The shelter shall develop and implement procedures to ensure the confidentiality of records pertaining to any individuals provided family violence prevention or treatment services.
8. The shelter shall have a policy manual which includes the shelter's purpose, population served, program description, non-discrimination policy and confidentiality statement.
9. The shelter shall provide for an evaluation of the effectiveness of the services offered, at least annually.

PERSONNEL

1. The shelter shall have a table of organization of all paid staff working in the shelter. There shall be written position descriptions for each position type, which includes job responsibilities and qualifications.
2. The shelter shall have written policies for the selection of all paid personnel in conformance with the EEO guidelines.
3. The shelter shall have adequate, trained, on-site staff coverage during all hours the shelter is open to residents, unless individual secured units are provided.
4. All shelter staff shall receive training in at least the following:
 - a. emergency evacuation procedures;
 - b. agency operating procedures.

5. All relevant direct service staff shall receive additional training in at least the following:
 - a. non-violent crisis intervention techniques;
 - b. referral procedures to relevant community resources;
 - c. first aid procedures.

FACILITY

1. The shelter shall comply with applicable local fire, environmental, health, and safety standards and regulations.
2. The shelter shall be clean and in good repair.
3. The shelter shall have reasonable access to transportation services.
4. The shelter shall provide a bed or crib for each guest except in extenuating "overflow" conditions or unless the shelter has Department of Development exemption based on size and/or type of shelter. The shelter shall make provision for clean linens for each client. There shall be procedures to provide for the sanitizing of all linens and sleeping surfaces.
5. The shelter shall provide sufficient showers/baths, wash basins and toilets which are in proper operating condition for personal hygiene. These should be adequate for the number of people served. Clean towels, soap and toilet tissue shall be available to each client.
6. The shelter shall have private space to meet with clients.
7. The shelter shall have laundry facilities available to clients or a system available for like services.
8. The shelter shall have a fire safety plan which includes at least the following:
 - a. posted evacuation plan;
 - b. fire drills, conducted at least quarterly;
 - c. fire detection systems which conform to local building and fire codes;
 - d. adequate fire exits;
 - e. adequate emergency lighting.
9. The shelter shall have adequate provision of the following services:
 - a. pest control services;
 - b. removal of garbage;
 - c. proper ventilation and heating/cooling systems;
 - d. to ensure that entrances, exits, steps and walkways are kept clear of garbage and other debris, ice and snow and other hazards.
10. The shelter shall provide adequate natural or artificial illumination to permit normal indoor activities and to support the health and safety of occupants. Sufficient electrical sources shall be provided to permit the use of essential electrical appliances while assuring safety from fire.

FISCAL MANAGEMENT

1. There shall be an accounting system, which is maintained in accordance with Generally Accepted Accounting Principles (GAAP).
2. The shelter shall have a record of accountability for client's funds or valuables the shelter is holding.
3. The shelter shall receive an annual independent audit or audit review.
4. The shelter shall have internal fiscal control procedures, which are reviewed and approved by the Board of Trustees.

FOOD SERVICE

1. Shelters providing food service shall make adequate provisions for the sanitary storage and preparation of foods.
2. Shelters providing food for infants, young children and pregnant mothers shall make provisions to meet their nutritional needs.
3. Shelters shall provide, or arrange food services to clients or make known the available services nearby.

HEALTH

1. The shelter shall have available at all times first aid equipment and supplies in case of a medical emergency.
2. All staff on duty shall have access to a telephone. Emergency telephone numbers shall be posted conspicuously near the telephone.
3. The shelter shall assure that at least one staff person on duty is trained in emergency first aid procedures.
4. The shelter shall have a procedure for making referrals to appropriate medical providers.
5. The shelter shall have a written policy regarding the possession and use of controlled substances as well as prescription and over the counter medication.
6. The shelter shall have a written policy regarding the control of infectious diseases, such as HIV, tuberculosis, etc.
7. The shelter shall provide a locked place for the storage of medications.

OPERATIONS

1. In addition to sleeping arrangements and food, the shelter shall provide the following basic needs:
 - a. humane care which preserves the individual dignity;
 - b. a clean environment;
 - c. reasonable security;

- d. referrals to other agencies.
2. The shelter shall have written policies for intake of clients and criteria for admitting people to the shelter.
3. The shelter shall maintain an attendance list which includes, at least, the name and sex of each person residing in the shelter.
4. The shelter shall post and read, or otherwise make known, the rules, regulations and procedures of the shelter.
5. The shelter shall post and read, or otherwise make known, the rights and responsibilities of shelter clients that shall include a grievance procedure for addressing potential violations of their rights.
6. The shelter shall report child abuse and endangerment as required by law.
7. The shelter shall only require clients to perform duties directly related to daily living activities within the shelter.
8. The shelter shall provide access to a public or private telephone for use by shelter clients to make and receive calls.
9. The shelter shall maintain records to document services provided to each client.
10. The shelter shall provide accommodations for shelter clients to store personal belongings.
11. The shelter shall provide a safe, secure environment and have policies to regulate access.
12. The shelter shall have a policy regarding the control of weapons.
13. The shelter shall encourage the involvement of clients in the decision making processes of the shelter. This can be accomplished in a variety of ways, including having resident advisory councils to give input into the operations of the shelter, or having homeless or formerly homeless people on the board, or having homeless or formerly homeless people trained and hired as staff, etc.
14. The shelter shall allow current clients to use the shelter as a legal residence for the purpose of voter registration and the receipt of public benefits.
15. The shelter shall maintain a daily log to record at a minimum all unusual or significant incidents.
16. The shelter shall have written policies for consensual and nonconsensual searches.

Excerpted from Shelter Standards Clarification Manual
www.cobbio.org/resources/shelterstandards.pdf

Disaster Planning

After September 11, 2001, every community in America became keenly aware of the need for effective disaster planning and response—in response to terrorism, natural disaster, or any other disaster that might strike. Many homeless advocates recognized that there was already a “disaster” of vast proportions affecting millions of homeless people all over the country, and have attempted to develop community-wide planning processes around response to homelessness as well.

Prior to the hurricane season of 2005, some communities were more effective than others in planning for natural disaster. Among the lessons from this hurricane season is the fact that a natural disaster in one area can have a dramatic and an almost immediate impact on an area hundreds of miles away, as large numbers of people in need of shelter and services flee the disaster.

The following articles originally appeared in *Healing Hands*, August 2004, to provide support to Health Care for the Homeless Projects in responding to disaster. They are reprinted here because they outline important concepts of community collaboration and coordinated response to disaster.

Disaster Planning Requires Time, Resources, Collaboration

Health care providers have long prepared for natural disasters such as floods, hurricanes, blizzards, and tornadoes, but they are now acutely aware of the need to prepare for nuclear, biological, or chemical (NBC) terrorism, as well. Lacking protection from the elements, homeless people are especially vulnerable to natural and manmade disasters and Health Care for the Homeless providers are at various stages of emergency preparedness. The articles in this issue of Healing Hands examine preparations being made by the health care community, a special role for HCH mobile providers, and emergency management standards required by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

The word “emergency” has taken on new meaning since the terrorist attacks of September 11, 2001. JCAHO defines an emergency as a natural or manmade event that suddenly or significantly disrupts the environment of care (e.g., damage to a building from a storm), disrupts care and treatment (e.g., loss of utilities), or changes or increases demands for an organization’s services (e.g., bioterrorist attack).

Prior to September 11th, the Boston Health Care for the Homeless Program was involved in emergency preparedness as then defined—“for hurricanes, fires, power outages, and other natural or accidental emergencies that would affect our clients or the health care delivery system,” says **Greg Wagoner, MD**, Medical Director. “Since September 11th we’ve been involved in more intensive planning for potential mass casualty events that are purposely committed.”

Health care providers are aware of the need for emergency planning—according to a 2003 survey of federally qualified health centers by the National Association of Community Health Centers (NACHC), 73 percent of health centers that responded have a disaster plan. However, only 9 percent of health centers feel *adequately* prepared for a community disaster (emphasis original). Survey respondents cited the need for training, followed by improved equipment and supplies.

DISASTER PLANNING 101

Communities and the HCH providers that serve them are at varying levels of readiness for natural and manmade disasters. Those that appear well prepared share several things in common: a specific emphasis on disaster planning, close coordination among community providers, an incident command structure and alternate methods of communication, plans to “shelter in place” (create a barrier between individuals and potentially contaminated air outside) or evacuate, and knowledge of how they fit into the broader community’s emergency plans.

Conduct a hazard vulnerability analysis (HVA). Modified emergency management standards issued by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in January 2001 require JCAHO-accredited health care organizations to conduct a formal, documented hazard vulnerability analysis (HVA). An HVA, Dr. Wagoner explains, describes the probability that a particular type of emergency will take place and how it will affect your agency and your clients. “In Boston, the probability of earthquake is low, but its

impact would be high,” he says. The key is to identify how prepared you are for each hazard that is likely to occur.

Develop, implement, and test your plan. Disaster management plans must be comprehensive but easy to use, updated regularly, and tested in emergency drills. “It is no longer sufficient to develop disaster plans and dust them off if a threat appears imminent,” according to JCAHO. “Rather, a system of preparedness must be in place everyday.” In the wake of September 11th, St. Vincent’s Hospital Manhattan discovered that its plan was too voluminous to be useful to staff, says **Yvonne Wojcicki, MS, MTASCP**, Safety Officer for St. Vincent’s Hospital Manhattan and Director of NBC Preparedness for St. Vincent Catholic Medical Centers. “We’ve streamlined our plan with a series of checklists and designed it so you can ‘rip a page and go,’” Wojcicki says.

JCAHO requires that disaster plans address the four phases of emergency management: mitigation, preparedness, response, and recovery.

Mitigation activities lessen the severity and impact of a potential emergency (e.g., having generators in the event of a utility failure). In addition to its role of providing federal relief in the wake of a natural or manmade disaster, the Federal Emergency Management Agency (FEMA) offers pre-disaster mitigation training materials for community-based organizations and emergency managers.

Preparedness activities build organizational capacity to manage the effects of an emergency should one occur. They include:

- Create a list of local emergency numbers.
- Make a list of all staff.
- Determine when staff will likely be available.
- Decide how to communicate with staff and clients.
- Share names of designated persons in charge with other service providers.
- Post the emergency plan on a bulletin board.
- Develop an evacuation plan.
- Prepare a kit to take with you.
- Create a plan to shelter in place.

Planning for alternate methods of communication among staff and other emergency personnel is important because land lines or cell phones may be inoperable. Options include two-way radios, pagers, wireless personal digital assistants (PDAs), satellite phones, and designated Web sites.

Response activities control the negative effects of emergencies. This involves both emergency management and actions that all staff must take. In the event of a mass casualty incident in Boston, HCHP would set up an incident command structure at its 90-bed respite center, Barbara McInnis House. The incident commander would analyze the situation and activate appropriate policies and procedures.

At the Alameda County Public Health Department HCH program, all staff carry a card with detailed information of what to do in the event of a natural disaster (e.g., earthquake) or

terrorist attack, notes **G.G. Greenhouse, MSW**, Director. Patient service representatives at Camillus Health Concern, Inc., in Miami are instructed to cancel patient appointments for the next 2 days when a hurricane watch is issued. Signs on the doors alert potential walk-in clients, says **Mary Langer**, Administrator of Office Operations.

Recovery actions are directed at restoring essential services and resuming normal operations. Recovering lost revenue, if possible, and offering support to staff are two recovery activities.

Collaborate with the community. Effective disaster plans can't be developed in isolation, but collaboration is not always easy, Dr. Wagoner notes. "The concept of community-wide preparedness is new to most health care organizations," according to JCAHO. Many communities are "waiting for someone to call the meeting." **Anthony Donovan, BSN**, didn't wait for someone else to call. Donovan is manager of the Keener Clinic, one of 32 clinics serving homeless people operated by St. Vincent's Hospital Manhattan Department of Community Medicine. On September 12, 2001, he called other health care and emergency organizations on Ward's Island, where the Keener Clinic is located, including the Manhattan State Psychiatric Hospital and the New York City Fire Department training facility. "Now we know what resources we have and how we can help each other," Donovan says.

In preparation for the recent Democratic National Convention in Boston, HCHP met with government and community representatives to develop plans for homeless people who would be displaced by the tight security around the Fleet Center. Dr. Wagoner credits the fact that there were no incidents involving homeless people to this "well planned and coordinated effort."

New Orleans' freeze plan for homeless people is signed by all city agencies and nonprofit organizations that participate, and these groups meet monthly from September to March to monitor how the plan is working. When the temperature drops below 38 degrees in New Orleans, shelters remain open 24 hours a day and are allowed to double their occupancy, notes **Willie Mae Martin, MSW**, Director of HCH for the City of New Orleans Health Department.

Depending on the emergency, health care providers may be cut off from other agencies with which they have emergency arrangements. "We lost communications because the city office of emergency management was in the World Trade Center," Wojcicki says. "You have to prepare to handle an emergency alone."

Know the role HCH will play. As a primary health care provider, HCH may be called on to serve individuals impacted by a disaster. In Alameda County, CA, the HCH mobile medical van would be a first responder in the event of a chemical spill from the nearby Clorox® plant, Greenhouse says. In other cities, the primary role for HCH providers is to serve their own clients in the event of a disaster. "Our clients are very vulnerable physically and psychologically and we have to get to our sites to serve them," Donovan says.

Be prepared to treat casualties. After a flood or earthquake, health care providers may see common illnesses or injuries, but the prospect of NBC terrorism raises the stakes. "Few clinicians have presence-of-mind awareness of the signs and symptoms of bioterrorism

agents, such as anthrax, smallpox, and plague,” JCAHO notes. Only one quarter of family physicians surveyed about preparedness for bioterrorism felt prepared. Disaster casualties may not have physical injuries.

For every one physical casualty caused by terrorism, there are an estimated four to 20 psychological victims. This was the case in Manhattan in the days after September 11th, when St. Vincent’s Hospital prepared for victims that never came. Instead, they opened their family support center to thousands of family members of victims who needed something to eat, a shoulder to cry on, and possible word of their loved ones. By the time the city took over this role, St. Vincent’s had served some 6,000 people. “It was a powerful emotional experience,” Wojcicki says.

Homeless people also suffered emotional trauma as a result of September 11th, notes **Barbara A. Conanan, RN, MS**, Director of SRO and Homeless Programs for St. Vincent’s Hospital Manhattan Department of Community Medicine. “Often, our clients couldn’t articulate their feelings verbally, but they came in with physical complaints, such as chest pain and stomach aches for which there were no physical findings,” Conanan says. Those who had been previously traumatized, such as rape victims, were especially vulnerable.

Participate in training. In the NACHC survey, 94 percent of respondents cited training as their number one need related to emergency preparedness. In Tulsa, OK, staff of the Tulsa Day Center for the Homeless, Inc., are participating in a series of training modules sponsored by the Tulsa Citizens Corps. The Tulsa Day Center provides day and evening shelter and a nurses’ triage clinic. Staff are being educated about the impact of language and diversity issues in an emergency, among other issues. “If we’re sheltering in place, language barriers and special dietary needs may be an issue,” says **Judy Ward**, Development Director. Several Day Center staff will take Community Emergency Response Team (CERT) training, a 7-week course funded through the federal Citizen Corps program to teach emergency preparedness, disaster medical operations, and light search and rescue to members of the community.

Help homeless people plan for emergencies. Few HCH programs have the staff or resources to help homeless people prepare their own disaster plans. In Tulsa, the American Red Cross adapted its family disaster training to focus on the needs of people who are homeless. Case managers and outreach workers in Boston prepared homeless people for increased security at the Democratic National Convention and helped them make alternate plans.

Homeless people may be particularly vulnerable in a situation where individuals are told to stay at home. In Boston, HCHP is working on an addendum to its emergency plan that will spell out systematically how to help people on the street get to safe places.

Seek funding for disaster planning. Many HCH programs cite lack of funding as a significant barrier to disaster planning. In a 2001 survey of health centers, NACHC found that many lack financial resources for drugs, supplies, clinical training, and improving information systems.

In Boston, HCHP uses grants from foundations and the city Department of Public Health to support the work of its Emergency Preparedness Task Force, which meets every other week. A Hospital Bioterrorism Grant from the Health Resources and Services Administration (HRSA) has allowed St. Vincent's Hospital Manhattan to increase preparedness in such areas as communications and decontamination. In 2002, health centers and Primary Care Associations in eight states used funds from the Centers for Disease Control and Prevention (CDC) and HRSA to develop and implement disaster plans and purchase personal protective gear and communications equipment.

Take care of staff. Staff are on the front line of emergencies, and they must be supported so they can do their jobs effectively and confront their own emotional reactions. JCAHO emergency standards call for the management of staff activities—including housing, transportation, and incident stress debriefing—and staff and family support activities. Donovan uses guidelines for staff that help them prepare their own families beforehand, so they will be free to concentrate on their work. In the wake of September 11th, St. Vincent's Hospital Manhattan has held numerous in-service programs for staff, “but some still have difficulty talking about it,” Donovan says.

Celebrate resilience. September 11th highlighted for Donovan the resilience of human beings, including those homeless people who volunteered to help. Ultimately, he notes, a “disaster levels the playing field. We're all vulnerable.”

This article originally appeared in Healing Hands, August 2004.

When Disaster Strikes, Health Care for the Homeless Takes to the Streets

It started raining on a Friday, and it looked like a normal day. Nobody realized how much and how fast it was raining,” says **Marion Scott, MSN, RN**, Project Director of the Harris County Hospital District HCH program in Houston, TX. When Tropical Storm Allison subsided after 5 days in June 2001, nearly 37 inches of rain was recorded at the Port of Houston. Allison is the costliest natural disaster in Houston’s history.

OUTREACH TO THE NEWLY HOMELESS

The ranks of homeless people swelled as a result of the storm, and HCH responded. “The street outreach model is an excellent foundation for responding to disasters,” Scott says. As The Salvation Army, Red Cross, and Federal Emergency Management Agency (FEMA) set up relief sites, HCH parked its mobile medical van outside. Clinical staff treated skin conditions caused by wading in high water, diarrhea, and psychological trauma.

In collaboration with City Health Department personnel, they gave immunizations for tetanus. Patients who lost medications (and in many cases their cars) and/or those needing additional primary care services were given tokens and taxi vouchers to go to the nearest Hospital District Community Health Center.

Homeless shelters also expanded their services to accommodate newly homeless individuals and HCH began conducting increased evening hours at shelter clinic sites, as well. The HCH received additional one-time funding from HRSA to support disaster intervention efforts. Scott has requested funds to purchase a 26-foot mobile medical unit to expand street outreach efforts and to provide increased penetration into communities affected by catastrophic events.

TRAINING THE RED CROSS

The October 1989 Loma Prieta earthquake, measuring 7.1 on the Richter scale, was centered 60 miles south of San Francisco. Sixty-two people died, 3,000 were injured, and property damage totaled \$7 billion.¹¹ The Alameda County Public Health Department HCH program sent staff to Red Cross planning meetings. “We already had a schedule of shelters for homeless people we visited, so we fit their shelters in, along with seeing our regular clients,” says G.G. Greenhouse.

In addition to treating individuals made homeless by the earthquake, HCH staff trained Red Cross nurses on medical problems they might encounter in homeless people, such as lice and scabies. “Most people in their shelters had been housed, but anybody on the streets could show up,” Greenhouse says. HCH staff served residents of Red Cross shelters up to January of the following year. Though they never recovered their costs for this additional work, Greenhouse says, “If disaster strikes, you do what you have to do.”

This article originally appeared in Healing Hands, August 2004.

OK, Now What? Next Steps

Shelter Health:
Essentials of Care for People Living in Shelter

Next Steps

For ongoing training

1. Commit to a culture of learning within your organization and your community.
2. Plan at least one community-wide training this year that brings people together from throughout the community to learn from one another and outside experts.
3. Agree on structures for the sharing of information between agencies—email list serves, monthly networking meetings, quarterly tours of each other’s organization.

For community dialogue

1. Work to establish Guiding Principles and community-wide Shelter Standards that will ensure high quality care for those who find themselves staying in shelters.
1. Establish a network or coalition of shelter providers if one does not already exist. Meet regularly.

For using this Guide

1. If you are a health care provider, use the material in this guide as a framework for providing your own training in the community. [NOTE: Please see the “Tips for Trainers” that follow.]
2. Use this guide as part of an orientation for all new staff and volunteers.
3. Use the tool-kits (included in electronic form on the companion CD) as handouts, posters, flyers, and in other educational efforts for staff and residents.

Tips for Trainers

Training adults is an adventure and journey for both student and trainer. To maximize the benefits of the journey, to make it useful and effective, a trainer needs to consider: 1) the principles of adult learning, 2) the learning styles of adults, and 3) the logistics of developing and implementing a training program. In this appendix, we provide several key tips for trainers to lead successful trainings. Checklists and aids are provided to use or adapt for local trainings.

I. Principles of Adult Learning

The purpose of this section is to provide information on the principles of adult learning and how trainers can transform these principles into action when they facilitate trainings.

Researchers have said that people will remember:

20% of what they hear
30% of what they see
50% of what they see and hear
70% of what they see, hear and say
90% of what they see, hear, say, and do

Trainings try to achieve a successful balance between what people *see*, *hear* and *do* to maximize the learning that can happen. The modules in this curriculum try to achieve this balance by using visual aids (PowerPoint slides and handouts that people can “see”), information in presentations (facts and ideas that people can “hear”), opportunities for discussion and sharing ideas (that people can “say”), and opportunities to demonstrate new skills (on worksheets and in small group discussions that people can “do”).

Malcolm Knowles, a well known educator, has put forth **ten principles for adult learning**. For those who conduct and plan training, these principles offer a checklist for trainers in both the design and implementation of their trainings. The ten principles are:

1. Adults need to be self-directed learners.
2. Learning is a lifelong process.
3. For learning to take place, the learner must be actively involved in the experience.
4. Adults learn by doing.
5. Situations, problems, exercises and examples must be relevant, realistic, and immediately applicable.
6. Adults relate current learning to what they already know. Thus, trainers benefit from knowing the background of their participants.
7. There are several learning domains. A variety of learning activities stimulate learning and appeals to the range of learning styles.
8. Learning flourishes in an environment that is:
 - Informal
 - Nonjudgmental
 - Based on mutual trust
 - Collaborative
 - Open and authentic
 - Humane
 - Supportive

9. Learners benefit from an opportunity to identify their own learning needs.
10. The trainer is a facilitator of learning and a catalyst for change. The responsibility for learning and making change resides with the learner.

This chart is derived from the experiences of many professional trainers who have applied the principles of adult learning to their specific training practices.

Principles of Adult Learning	Application in Training
Adults expect to learn information that is relevant to them.	Focus on real problems. It is important to create objectives.
Adults expect to learn information that has immediate application to their lives. They need to “see the reason” for learning something.	Stress how the learning can be applied, or how the information will be useful to people in their work.
Adults are goal-oriented in their learning.	Obtain information on the learners’ goals, and show participants how the training will meet those goals.
Adults want their learning to be problem-oriented.	<ul style="list-style-type: none"> • Take time to achieve consensus on the problem that will be addressed. • Design problem-solving activities and provide opportunities for practicing “solutions.” • Anticipate problems in applying new ideas, and offer strategies to overcome problems. • Trainers can give overviews and summaries.
Adults have enormous experience and a wealth of information from work and private lives that should be drawn into discussion. They often start out knowing more than they think they do.	<ul style="list-style-type: none"> • Relate the materials to the past experiences of the learner. • Focus on the strengths that learners bring, not only their gaps in knowledge. • Listen to and respect the opinions of learners. • Encourage learners to be resources to each other and to you. • Connect the learning to the existing knowledge and experience base in the room. • Value experience in learning.
Adults have established values, beliefs, and opinions.	<ul style="list-style-type: none"> • Demonstrate respect for differing beliefs, religions, value systems, and life styles. • Acknowledge that people are entitled to their values and opinions, but everyone may not share these ideas. • Allow debate and challenge of ideas.
Adults have pride.	<ul style="list-style-type: none"> • Support the learners as individuals. • Create an environment where people will not feel put down or ridiculed. Allow people to admit confusion, ignorance, fears, biases, and different opinions.

	<ul style="list-style-type: none"> • Acknowledge and thank learners for their responses and questions. Treat all questions and comments with respect.
Adults learn best when they are actively engaged, when they learn by doing.	<ul style="list-style-type: none"> • Provide opportunities for small group discussion, hands-on practice, or analyzing a case study.
Adults want more than information. They want practical answers to their questions and problems. They need to integrate new ideas with what they already know.	<ul style="list-style-type: none"> • Help learners recall what they already know that relates to the new information. • Ask what they know about the topic and what they would like to know. • Suggest follow-up ideas and next steps. • Trainings should include: <ul style="list-style-type: none"> ○ time to learn new material ○ time to apply new skills
Adults learn well from each other.	<ul style="list-style-type: none"> • Set up the class so that participants can face each other. • Provide opportunities for participants to work together in small and large group discussions. • Allow debate, challenge and discussion of ideas.
Adults learn best in an informal and comfortable environment.	<ul style="list-style-type: none"> • Include breaks. • Allow for spontaneous discussions. • Provide food or drink.
Adults want to learn.	<ul style="list-style-type: none"> • Assume participants want to be there. • Find out the participants' motivations. • Identify training goals that may coincide with their motivation.
Learners deserve respect.	<ul style="list-style-type: none"> • Avoid jargon and don't "talk down" to learners. • Provide opportunities for learners to teach each other through discussion and small group work. • Acknowledge the wealth of experiences participants bring with them. • Validate the value of their experience. • Listen. • Learn from people in the room.
Adults are self-directed learners.	<ul style="list-style-type: none"> • Remain flexible and adjust your presentation to their needs. • Ask what people already know/want to know about the topic. • Remember the facilitation role of guiding participants.

Trainers can incorporate these principles and goals in other ways as well:

Remember to	How:
Find out the specific learning needs and interests of individual participants. Your teaching can then be tailored accordingly.	Conduct brief needs assessments prior to the training session or immediately at the beginning of the training session.
Respect differing points of view.	Design programs that allow viewpoints to be shared.
Respect the experience of the learners.	<ul style="list-style-type: none"> • Avoid asking adults to try a new skill in front of a large group. • Acknowledge the wealth of experience in the room, and encourage participation. Design questions that tap this resource. • Involve and engage participants to share examples from their own experience if appropriate.
Appeal to a range of learning styles.	Make sure your training includes listening, seeing new material, and doing something with the new material. By including all three, we appeal to different learners and increase everyone’s capacity to learn.
Build in repetition.	Plan to repeat certain key concepts. Adult learners need to hear something six or seven times to have it sink in.
Create a comfortable space.	<ul style="list-style-type: none"> • Avoid long lectures with no breaks • Try to create a space with few distractions, where dialogue and privacy are allowed. • Try to build an environment of mutual trust between all learners, including the trainer.
Allow participants to “diagnose” or identify the problem.	<ul style="list-style-type: none"> • Have participants use questionnaires, surveys, and assessments before and after the training. • Share results with them.
Offer participants an opportunity to evaluate their own learning.	Provide a variety of activities that offer opportunities for participants to assess their learning and capacity.

II. Learning Styles of Adults

People come to trainings with a variety of learning styles. Trainers need to offer learning opportunities that appeal to a variety of these styles, so that no participant is left behind.

While all people learn in multiple ways, many have a predominant learning style. For example:

Feelers

Feelers are people-oriented. They enjoy learning that explores people's attitudes and emotions. They like open, unstructured learning environments. They enjoy working in groups and activities where they can share their opinions and experiences.

Observers

Observers prefer to watch and listen. They enjoy learning experiences that allow them to consider ideas and opinions. They thrive in experiences that promote learning from discovery.

Thinkers

Thinkers rely heavily on logic, thought and reason. They enjoy sharing ideas and activities that require analysis and evaluation. They may prefer to work independently. Role-plays are not preferred.

Doers

Doers like to be involved in the learning process directly. They enjoy practice opportunities, are focused on the relevance of their learning, and want information in concise formats.

Some learners need visual aids in addition to information. Others need tools to assist them in applying the information. Still others require multiple opportunities to practice new skills or apply information as a way to build confidence with the information or skill. Trainers need to remain flexible and have multiple techniques available to them to ensure that learners are having a comfortable experience that appeals, in some way, to their own preferred style of learning. A successful training incorporates activities that address all of these learning styles.

III. Developing and Implementing a Training

Training requires a certain amount of “advance work” that the trainer must complete in order to build a safe and comfortable environment for learning, and ensure the training goes smoothly. These tasks are the responsibilities of the trainer or sponsor of the training.

Needs Assessment as the Basis for Setting the Training Goals and Objectives

The key to a successful training is ensuring that the goals and objectives meet the needs of participants. A first step toward understanding the needs of participants is to conduct a brief needs assessment at least one-two weeks prior to the actual training. For example, trainers can ask three or four questions that help identify some of the key content areas as well as the participants' styles of learning. You might ask:

- How long have you been working in this field?
- What do you feel is critical to your becoming more successful in your work?
- What are your expectations for this training?

These questions could be asked by telephone or through email if time and resources permit. If time is limited, a brief needs assessment can also be conducted at the beginning of the training. Another option is to conduct an icebreaker exercise that provides the trainer with some sense of the participants' level of knowledge and experience.

Setting Goals

Goals are established to clarify what participants can expect to get out of the training session. Goals are broad, participant-oriented, and are not necessarily measurable.

Goals should be shared and reviewed with participants at the beginning of the training session. Trainers can present pre-established training goals, while also asking participants what they want to achieve during the training. Often the two can be combined. By asking participants for their goals, the trainer has a chance to present a realistic portrait of what will be achieved, and to clarify misunderstandings about the purpose of the training.

Creating Objectives

Objectives describe how the goals will be achieved. They are usually specific, relevant, measurable, and attainable for participants. Objectives explain what participants will be able to do by the end of the training session. By the end of the session participants will be able to:

- Demonstrate...
- Describe how...
- Identify...

Trainers should share the objectives with participants and post them during the session, so participants can see where they are going during the training session. Trainers may want to check in with participants periodically and see if participants had other expectations for the objectives.

Designing a Training Program

Once the training goals and objectives are established, the next step is to outline the content of the training. Think about what activities and information need to be included in the session to achieve the objectives. The content needs to accommodate both the time allotted to the training and the number of participants.

For large groups (greater than 20 persons), think about breaking people down to work in small groups or doing a mix of small group work and presentations so that all participants are active in the learning process. For smaller audiences, think about exercises that will foster maximum interaction between participants. Remember to develop a variety of training activities to ensure the capacity to remain flexible.

Complete a Task List in Preparation for the Training

Once the training goals, objectives, and content are established, it is time to focus on other logistics that are important for a successful training. Developing a checklist can help complete tasks and ensure a successful experience for both the trainer and participants.

Before the training, make sure to...	Done/ Not Done
<p>Check the training space ahead of time to make sure there is enough room, bathrooms are in order, and appropriate materials and equipment are available. Examples:</p> <ul style="list-style-type: none"> • Overhead projector and screen (or blank wall) • Adequate outlets, extension cords • TV/VCR/LCD • Easel, flipchart, markers 	
<p>Prepare for equipment failure and other potential disasters. Have back up materials in different formats (for example: have flipchart <i>and</i> overhead available).</p>	
<p>Prepare handouts, overheads, and/or flipcharts, and arrange them so you can use them easily during the training.</p>	
<p>Prepare a few back-up activities in case the training ends early or an activity isn't working with the group. Assemble materials for these back-up activities.</p>	
<p>Make handouts and visual aids available for the group. You can prepare folders or have participants collate materials at the beginning of the training. A packet gives participants a place to save handouts, business cards and other materials. Include your contact information. Make sure paper and pens or pencils are available so people can take notes.</p>	
<p>Arrange to have nutritious snacks available.</p>	
<p>Set up the workshop room so it is appropriate for the size of the group and the types of activities you will be doing. Tables are needed for writing exercises, open space is necessary to do activities, and chairs in a circle or semi-circle are more conducive to discussion than rows. Decide what will work best and set up the room accordingly. (Options may include: rows, U-shape, circle, square or rectangle)</p>	
<p>Post a large sheet of newsprint near the front of the room and write "Parking Lot" at the top. Use this sheet to write down questions or topics people bring up that need to be addressed at a later point in the workshop, or that need follow-up after the training. This will be your reminder list.</p>	
<p>Prepare sign-in sheets and have name tags ready for participants.</p>	
<p>Review the workshop agenda and information beforehand. The participants will know if you are unprepared, and they will lose faith in your credibility as a group leader.</p>	
<p>Prepare to begin and end on time. Being prompt demonstrates respect for the participants.</p>	
<p>Develop your own objectives for the training. Also prepare a written evaluation that measures if you have achieved those objectives and provides an opportunity for participants to share other observations with you. Make sure you have enough copies for participants and have allotted time during the training for them to complete it. Keep the evaluation relevant to participant's lives and provide an opportunity for participants to reflect on what they can use from the training. Make the evaluation anonymous or name optional because this will allow privacy for respondents and ensure honest responses. Have a designated place where people can leave their evaluations before they leave the training.</p>	

Excerpted and adapted from A Kaleidoscope of Care: Responding to the Challenges of HIV and Substance Use, Health & Disability Working Group, Boston University School of Health <http://www.aids-etc.org/aidsetc?page=et-04-03>

Lessons Learned

As we have met with homeless health care providers around the country, and as we have talked with disaster relief service professionals since Hurricanes Katrina, Rita, and Wilma, it has become clear that there are a great many lessons to be learned—both positive and negative—from our communities’ responses to crisis. This is true for programs that address chronic homelessness, provide care for people fleeing domestic violence, or serve people displaced by natural disaster.

The “Wisdom from the Front Lines” printed here could have been written by the staff and volunteers of any homeless shelter in America, or by any group of volunteers responding to natural disaster. It is our hope that readers of this guide can take the wisdom of one site and apply it to whatever setting in which they find themselves.

Wisdom from the Front Lines

The advice below represents the collective wisdom of several health care providers on the Mississippi Gulf Coast after Hurricane Katrina. They were compiled by Maria Claudia Escobar, Family Nurse Practitioner from NYC Care for the Homeless, while volunteering at Camp Coast Care in Long Beach, Mississippi.

Recent storms have exposed the inadequacies of the pre-existing health care safety net. Even before the storm, the few facilities that were supposed to meet the needs of the poor and uninsured were not doing such a good job, and patients had to wait many months for appointments. **Now, as a result of recent disasters, there will likely be many more folks without coverage.** No work, no benefits. And most of the local medical facilities running at present in the community will only take people with insurance. So there is an enormous need to provide care for people who can't get care elsewhere.



In order to respond effectively, shelter providers should:

1) Be clear on what your clinic/unit will be from the outset.

Make clear decisions on whether your services will be temporary or long term, and on what population you are expecting to reach. These decisions will guide many tactical choices down the road.

Temporary health facilities can be an impediment to getting long-term structures up and running. Coordinating all the volunteers and donated supplies takes focus and resources away from longer term, more substantive solutions.

2) Have a clear plan for how to utilize volunteers.

If you will be using volunteers, it's important to have a central processing place to coordinate volunteer resources, including the issuing of licenses prior to volunteers' arrival.

When possible, use local expertise. After disasters, there are inevitably a large number of volunteers coming in to help from all over, but it is critical to develop local capacity to respond as well.

3) Have a clear plan for how to deal with medications and vaccines.

Make decisions on what meds can be prescribed or given out (i.e. narcotics, sleep meds, pain meds). Make plans for how to care for patients who need medication but have no health insurance and do not qualify for Medicaid or other programs.

Try to get pharmacy or med distribution center connected to a computer program or national connection that can provide: 1) drug interactions, contraindications; 2) create historical order of what meds patient was on in past, and med changes.

Identify what vaccines are needed and set protocols for usage and distribution (due to cost and limited supply, i.e. Tetanus, flu shots).

4) Clearly identify needs and match up with resources and donations.

Donations and volunteers must be helpful and meet a high priority need.

5) Use approaches to care that are based on other successful models.

The format Jennifer Knight and the staff at Camp Coast Care used to set up the medical unit was based on what the church has used on medical missions overseas in the past. The usage of space and its function has been key to a smooth operation.

6) Ensure stable telephone service as quickly as possible after a disaster.

Get CENTRAL COMMUNICATIONS. Pay to have a land line for telephones. Do not rely on individual staff members' cell phones.

7) Provide for the mental health needs of displaced persons, staff, and volunteers.

Organize support groups and consider what venue/agency is best to host them.

Recognize and address survivors' guilt. Consider finding ways of using survivors as volunteers to help out those who are victims.

Address stress management for staff and volunteers. Provide training on techniques of identifying stress and depression and helpful coping tools for staff, volunteers, and patients.

Shelter Health:
Essentials of Care for People Living in Shelter

More Resources

Shelter Health:
Essentials of Care for People Living in Shelter

Shelter Health:
Essentials of Care for People Living in Shelter

Health Care for the Homeless

The National Health Care for the Homeless Council
PO Box 60427 Nashville TN 37206-0427
(615) 226-2292
www.nhchc.org/

The Health Care for the Homeless Information Resource Center
Policy Research Associates, Inc.
345 Delaware Ave. Delmar NY 12054
(518) 439-7415
www.bphc.hrsa.gov/hchirc/

Federal Agencies

Health Resources and Services Administration, Bureau of Primary Health Care
U.S. Department of Health and Human Services
Parklawn Building □ 5600 Fishers Lane Rockville, Maryland 20857
Telephone: (301) 594-4303
www.hrsa.gov/

Substance Abuse and Mental Health Services Administration
The U.S. Department of Health and Human Services
200 Independence Avenue, S.W. Washington, D.C. 20201
Telephone: 202-619-0257 Toll Free: 1-877-696-6775
www.samhsa.gov

Centers for Disease Control and Prevention
Telephone: 800-CDC-INFO □
www.cdc.gov/

Interagency Council on Homelessness
The United States Interagency Council on Homelessness
409 Third Street SW Suite 310 Washington, D.C. 20024
Telephone (202) 708-4663
www.ich.gov/

Federal Emergency Management Agency
500 C Street, SW Washington, D.C. 20472
Phone: (202) 566-1600
www.fema.gov/

Continued on next page.

Shelter Health:
Essentials of Care for People Living in Shelter

Disaster Response

The American Red Cross
2025 E Street, NW
Washington, DC 20006□
Phone: (202) 303-4498
www.redcross.org/

Doctors Without Borders
333 7th Avenue, 2nd Floor
New York, NY 10001-5004
Phone (212) 679-6800
www.doctorswithoutborders.org/

Other Organizations Focusing on Homelessness

National Coalition for the Homeless
2201 P St NW
Washington, DC 20037
Phone: (202) 462-4822
www.nationalhomeless.org

National Law Center on Homelessness and Poverty
1411 K Street NW, Suite 1400
Washington DC 20005
Phone: (202) 638-2535
www.nlchp.org

National Alliance to End Homelessness
1518 K Street NW, Suite 410
Washington, DC 20005
(202) 638-1526
www.endhomelessness.org

National Center on Family Homelessness
181 Wells Avenue
Newton Centre, MA, 02459
(617)964-3834
www.familyhomelessness.org

List of Acronyms

<i>BPHC</i>	Bureau of Primary Health Care
<i>CDC</i>	Centers for Disease Control
<i>CHC</i>	Community Health Center
<i>FEMA</i>	Federal Emergency Management Agency
<i>HCH</i>	Health Care for the Homeless
<i>HRSA</i>	Health Resources and Services Administration
<i>ICH</i>	Interagency Council on Homelessness
<i>IHN</i>	Interfaith Hospitality Network
<i>MCN</i>	Migrant Clinicians' Network
<i>NCH</i>	National Coalition for the Homeless
<i>SAMHSA</i>	Substance Abuse and Mental Health Services Administration
<i>UNHCR</i>	United Nations High Commissioner for Refugees

Further Reading

- Fitzgerald, Helen. *The Mourning Handbook*. New York: Simon and Schuster, 1994.
- Herman, Judith Lewis. *Trauma and Recovery*. New York: Basic Books, 1992.
- McMurray-Avila, Marsha. *Organizing Health Services for Homeless People: A Practical Guide*, 2nd Edition. National Health Care for the Homeless Council, 2002.
- Miller, William and Stephen Rollnick. *Motivational Interviewing*, 2nd Edition. The Guilford Press, 2002.
- O'Connell, James J, Ed. *The Health Care of Homeless Persons: A Manual of Communicable Diseases and Common Problems in Shelters and on the Streets*. The Boston Health Care for the Homeless Program with the National Health Care for the Homeless Council, 2004.
- Schneider, John M. *Finding My Way: Healing and Transformation Through Loss and Grief*. Colfax, WI: Seasons Press, 1994.
- Werner, David, with Carol Thurman, and Jane Maxwell. *Where There Is No Doctor: A Village Health Care Handbook*. Hesperian Foundation, 1992.
- Wolfelt, Alan. *Understanding Your Grief: Ten Essential Touchstones for Finding Hope and Healing Your Heart*. Ft. Collins, CO: Companion Press, 2003.