

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 involve 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 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 bedrest, 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
- 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

Shelter Health:
Essentials of Care for People Living in Shelter

- 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

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.

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://anitrweb.org/homelessness/faqs/helping/hosting.html>

Shelter Health:
Essentials of Care for People Living in Shelter