chapter

4

EMERGENCY FACILITIES

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Introduction

One of the most core components to a homeless-serving system of care is the existence and operation of emergency facilities—often known as shelters. The basic idea with such facilities is that persons without safe housing can quickly gain entry to them, ideally for a short time, until they can leave the facility for housing. Such facilities can keep vulnerable persons alive until they have more appropriate accommodation.

Some large communities in high-income countries have many large facilities with considerable sophistication — e.g., specialized facilities for specific groups (e.g., youth, families, etc.), well-trained and well-paid staff, good data collection systems, and sophisticated methods of triaging need and placing people into housing. Having said that, many communities—often smaller municipalities—have much more rudimentary facilities, often operated by people who are new to the sector. Unfortunately, some communities have no emergency facilities at all.

This chapter has three main sections. The first provides an elaboration as to what emergency facilities consist of. The second discusses the challenges and limitations of emergency facilities. And the third discusses some promising practices in this area.

What do emergency facilities consist of?

Emergency facilities for people experiencing homelessness—sometimes known as hostels or shelters—are typically congregate facilities where persons without permanent housing can stay, usually free of charge. Sometimes people are only allowed to stay for limited periods of time (e.g., one to two weeks), while some facilities allow residents to stay indefinitely.

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The sort of communal facilities discussed in this chapter are common in North America but rare in the United Kingdom (and banned in Scotland).

Here are some features of emergency facilities for persons experiencing homelessness.

Physical structures. Due to cost constraints, these facilities have often been repurposed and were typically designed for other uses. Previous uses include offices, hospitals, warehouses, restaurants, factories, schools, church basements, garages and prisons. Having said that, some are purpose-built.

Funding sources. Funding varies considerably. Both government and private sources often provide funding to renovate and operate such facilities, and sometimes to build them from scratch.

Regulation. Government typically has rules, guidelines and recommendations—often related to health and safety¬—that emergency facilities must follow. These tend to be set by local governments, rather than national governments. Oversight varies a great deal across countries, and even within countries. Sometimes facilities are run by large non-profits, including faith-based organizations, that have their own policies as well.

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Various categories. While small communities may just have one emergency facility, large cities tend to have ones that cater to specific subpopulations—e.g., unaccompanied adults, unaccompanied men, unaccompanied women, families with children, youth and older persons.

Staffing. The most basic roles performed by staff at emergency facilities include intakes, conflict de-escalation/security, cleaning and food preparation. Persons working in emergency facilities are typically offered low pay and few if any benefits. Having said that, some facilities, especially government-run facilities, offer better remuneration in accordance with public sector union standards.

Services. The types of services offered at emergency facilities vary enormously, even within the same community. At a very basic level, these may consist of: staff assistance in the resolution of conflict among residents; a mat, bed, or area of a floor to sleep on; a blanket and sometimes a pillow; washrooms, laundry and shower facilities; the storage of belongings; food; telephones; and a postal address to receive mail. Other larger emergency facilities that are open during the daytime may provide: clothing; assistance finding permanent housing; help dealing with income assistance officials; employment support; social activities, such as arts and crafts; and assistance with other administrative matters (e.g., filing tax returns, ID replacement, applying for income assistance). Some emergency facilities also offer health services on site, whereby physicians and other medical professionals keep regular hours at the facility—such health services might include wound care, medication administration, mental health counselling, harm reduction supply distribution (e.g., sterile syringes, safer smoking kits, condoms), overdose responses, naloxone administration training and health-related assessments.

Patterns of stay. Patterns of stay by residents vary enormously, determined in part by each resident's individual circumstances, rules at the facility, services offered at the facility and the availability of affordable (and appropriate) housing. Researchers often group such stays into three categories: transitional (meaning the person's homelessness tends to self-resolve after just a few days or weeks); episodic (meaning the person cycles in and out of emergency facilities, in a rather unstable manner); and chronic (meaning the person stays in the emergency facility for many months and even years on end). Policy-makers often focus on trying to get chronic shelter-stayers out of emergency facilities, into housing, in order to free up emergency beds.

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Challenges and limitations of emergency facilities

Most emergency facilities are overcrowded. In some cases, there is just one foot (i.e., 30 cm) separating persons.

In principle, there is nothing terribly wrong with the existence of emergency accommodation. After all, it is inevitable that some people will sometimes need shelter in a pinch. In practice, however, emergency facilities are fraught with serious challenges, several of which are now discussed.

Poor physical structure. As discussed earlier in this chapter, most emergency facilities are not purpose-built. They are often in a state of poor repair, and some have nooks and crannies that reduce lines of sight for both residents and staff (creating safety risks for all).

Overcrowding. Most emergency facilities are overcrowded. In some cases, there is just one foot (i.e., 30 cm) separating persons. In other cases, vulnerable persons (including children) are in close proximity to strangers. Such overcrowding both increases disease transmission and contributes to conflict among residents, some of whom can be prone to violence.

Food insecurity. There is often a lack of food, especially healthy food, at emergency facilities. What is more, emergency facilities have limited ability to cater to dietary restrictions (e.g., allergies, religious restrictions). This contributes to poor health outcomes and further costs to healthcare systems. For example, taxpayers may appear to save money initially by not spending too much on the emergency facility, but may pay later when a person develops diabetes.

Inadequate hygiene facilities. Emergency facilities often have insufficient toilets, showers and laundry facilities, further contributing to health challenges, deteriorating self-esteem and conflict among residents.

Privacy in any real sense is virtually non-existent in most emergency facilities.

Lack of privacy. Privacy in any real sense is virtually non-existent in most emergency facilities. When residents sleep as little as one foot (i.e., 30 cm) away from strangers, information privacy is hard to preserve, as is privacy in a physical sense (e.g., having to change one's clothing in front of strangers, having a bathroom emergency in front of other persons).

Bed bugs and body lice. Bed bugs and body lice are small insects that can get into emergency facilities when they 'hitch a ride' to people's clothing, luggage, purses and backpacks. They bite and can cause a considerable amount of stress and can even carry disease. It can also be very challenging to remove them from a facility once they get in.

Community resistance. Many homeowners, apartment dwellers and business owners would prefer that emergency facilities not be located in

their neighbourhoods. Households fear for both their safety and property values; business owners worry that such facilities may be bad for business. This can make it challenging and time-consuming for operators to receive regulatory permission to open new emergency facilities.

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Sleep deprivation. When people sleep very close to total strangers, it can be challenging to develop proper sleep hygiene. As a result, persons sleeping in emergency facilities can suffer from sleep deprivation, which can negatively impact cognitive function, coordination, decision-making, blood pressure, immunity, digestion and overall mood.

Theft and assault. Considering the many challenges discussed above, it should come as no surprise to readers that theft, physical assault and sexual assault are common in many emergency facilities. This causes further trauma among a population that has already suffered more than its share.

Inadequate harm reduction services. Emergency facilities do not adequately respond to the overdose crisis. Such facilities focus on providing shelter and typically do not have a strong mandate to fully support persons who use illicit substances. Some emergency facilities refuse services to people under the influence. What is more, on-site use of illicit substances is almost always prohibited. Washrooms in such facilities can therefore become "de facto unsupervised consumption sites."[1] The use of illicit substances in washrooms also tends to limit the availability of toilets either because the toilets are clogged with paraphernalia or because someone is intoxicated and unable/unwilling to vacate the stall. The lack of available toilets may lead to tensions, and sometimes violence.

Lack of flow out of the facility. While some emergency facilities have a strong desire to help residents move on from the facility into permanent housing, most lack the resources to do this sufficiently. Most residents have very low incomes, many face discrimination and some require intensive social work support (sometimes known as 'wraparound' support) upon placement into housing. Since most communities have insufficient subsidized housing and insufficient social work support for higher-need tenants, many residents in emergency facilities are essentially in a holding pattern.

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1 Wallace, B., Barber, K., & Pauly, B. B. (2018). Sheltering risks: Implementation of harm reduction in homeless shelters during an overdose emergency. *International Journal of Drug Policy, 53,* 83-89. The quote has been taken from page 87 of the article.

Not surprisingly, all of the above challenges and limitations discourage the use of emergency facilities, leading among other things to the creation of encampments (discussed in Chapter 3 of this book). This decreased use also results in shelter use being an incomplete gauge of the actual amount of homelessness in any given community.

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Promising practices

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Shelter diversion is the process of discouraging the over-use of emergency shelters and exploring alternatives. The Region of Waterloo (located near Toronto) has been doing this for nearly a decade. They have a telephone number people call in order to access an emergency facility for the first time. Staff who answer the phone can do a proper intake and ask a lot of questions; they can also provide callers with funding for such things as transportation and food vouchers. For example, they can arrange transportation to other communities (e.g., where a person might have a safe place to stay, but just needs help getting there). Food vouchers can be provided in the case of someone wanting to access a shelter simply because they are hungry. Ultimately, referrals are made to help persons gain access to emergency facilities, but not as a first resort.

Housing support. At the Calgary Drop-In (a large emergency facility) new residents are assigned a housing worker immediately upon access, and a housing plan is put in place within a day. Staff then take residents to view units. Funding is provided by the shelter to assist prospective tenants with first month's rent, damage deposit, moving and other needs. All shelter residents who receive assistance with housing have access to at least three months of case management support (sometimes more).

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24/7 access. There are several advantages to keeping emergency facilities open 24 hours a day, 7 days a week. First, doing this can increase safety for residents. Second, it can encourage residents to access services provided inside the facility. Third, it allows people to catch up on sleep during the day. Fourth, it can promote community acceptance (by reducing visible homelessness during the day and likely discouraging rough sleeping). Many emergency facilities provide 24/7 access and have done so for decades.

Primary health care. At some emergency facilities, nurses provide wound care, medication administration, overdose responses and other health-related assessments. It is also common for physicians to make regular visits to some emergency facilities in order to: build trust and rapport with residents; provide episodic care for acute health conditions as well as longitudinal care for chronic conditions; and to facilitate the connection of patients to primary care or specialist care at traditional health care

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settings. During the COVID-19 pandemic, several pharmacists began going to emergency facilities to fill prescriptions written by medical professionals—pharmacists even started keeping regular hours at several Toronto emergency facilities.

Harm reduction. Homes First Society is a large provider of both emergency services and permanent housing in Toronto; they also operated hotels that were repurposed during the COVID-19 pandemic. Homes First has been particularly innovative with respect to harm reduction. Building on an approach to 'wellness checks' that they had begun approximately 10 years earlier, Homes First staff working at COVID hotels checked all bathrooms, showers, stairwells and smoking areas every 15 minutes. Most Toronto emergency shelters have similar wellness checks, and the City of Toronto has released a directive and toolkit that includes 'best practice' guidance related to harm reduction and emergency facilities.[2] Homes First Society also provides 24/7 barrier-free access to harm reduction supplies, requires all staff be trained on the use of naloxone for overdose response, and hangs naloxone in public spaces, washrooms, and shower areas for general use. Additionally, Homes First Society collaborates with external harm reduction partners who provide supervised consumption services, peer spotting programs and safer supply programs onsite to improve client safety and reduce overdose deaths.

Data collection (and sharing). There are many advantages of good client-level data collection at emergency facilities. When facilities have information about a new client, they can provide appropriate services from the get-go. And when facilities share client-level data amongst each other (with consent from clients), intakes at other facilities can be fast and seamless.

Evaluation. Ongoing data-collection and data-sharing can make it easier for operators of emergency facilities to engage in ongoing evaluation of their work. Ideally, operators should identify the desired outcomes of their programming as they develop programming, and should also identify how they will track progress in achieving those goals. Part of this evaluative work should involve participation from both residents and staff, ideally throughout the year. A credible third party should be involved in this process so that operators of emergency facilities are not evaluating their own work. Funders (e.g., government) can encourage this

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2 City of Toronto (2021, June 10). City of Toronto launches new toolkit to respond to an increase in overdoses in the homeless population. https://www.toronto.ca/news/city-of-toronto-launches-new-toolkit-to-respond-to-an-increase-in-overdoses-in-the-homeless-population/

by providing funding for such evaluative work. For example, shortly after announcing the launch of a new model of emergency facility in 2022, the Government of Alberta hired a team of external evaluators to assess the new model's effectiveness during its first year of operation.

Staffing needs. Operators of emergency shelters need to be very mindful of mental health and burnout amongst staff, keeping in mind that some research has found higher rates of post-traumatic stress disorder among front-line staff in the homeless-serving sector than among police, paramedics and Emergency Department nurses.[3] The Center in Hollywood is a California-based non-profit serving persons experiencing homelessness. They have made major efforts to improve staff wellness. For example, they grant up to 40 hours of mental health leave annually (separate from their sick leave allotment). Prior to this initiative, staff were calling in sick with little notice, and this had a negative impact on programming and client support. Now, front-line staff work with their supervisors to schedule mental health days in advance, and these planned absences offer management more control of scheduling.[4]

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3 Waegemakers Schiff, J., & Lane, A. M. (2019). PTSD symptoms, vicarious traumatization, and burnout in front line workers in the homeless sector. *Community Mental Health Journal, 55*(3), 454-462.
4 The Center in Hollywood's website is https://thecenterinhollywood.org/.

Conclusion

Emergency facilities vary enormously from one community to another. Some large communities have sophisticated emergency facilities, while other communities have none at all. Many emergency facilities are poorly funded, are over-crowded and face resistance by the local community. Theft and assault amongst residents are common. While many persons in need of shelter understandably avoid emergency facilities as much as possible, some get stuck in such facilities for years.

The good news is that promising approaches to the operation of emergency facilities abound.

The good news is that promising approaches to the operation of emergency facilities abound. These include: organized methods of diverting people away from shelters (in responsible ways); supporting residents of emergency shelters to access more appropriate accommodation as quickly as possible; the provision of primary health care on site; harm reduction innovations; good client-level data collection; rigorous evaluation; and proactive approaches to reducing staff burnout.

A lack of funding and regulatory leadership from government is often a cause of the many of the challenges and limitations discussed in this chapter. And conversely, important funding commitments and guidance from government are almost always needed in order for promising practices to thrive. Ideally, all orders of government should work collaboratively both with each other and with non-profit organizations delivering services. They should encourage promising practices while both respecting local context (e.g., unique needs and constraints of some communities) and offering the operators of emergency facilities room to innovate.

Further reading

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About this project

This is Chapter 4 of a sole-authored, open access interdisciplinary textbook intended to provide an introduction to homelessness for students, service providers, researchers and advocates. Focusing on the English-speaking countries of the OECD, it will discuss causes, solutions, challenges, successes, and innovations in the sector. It will serve as 'launching pad' for people new to the sector, as well as a refresher for experienced practitioners.

In addition to being open access, this book is different from other books in two key ways: 1) by focusing on all English-speaking countries of the OECD; and 2) by providing an overview of recent innovations in the sector—i.e., what's new, and what's working well?—making it useful to practitioners.

- The book's **intent** is primarily to serve as the main textbook for a university course designed for senior-level undergraduate as well as graduate students. It also serves as a resource for senior leadership in the homelessness sector.
- Book's **main themes**: contributing factors to homelessness; health conditions and health care challenges of persons experiencing homelessness; the unique needs of various subpopulations; staffing challenges in the sector; an in-depth examination of innovative practices; and solutions to homelessness.
- Book **objectives**: assist readers in understanding the fundamentals of homelessness; introduce them to both successes and ongoing challenges in the sector; and leave them feeling better-informed, able to make critical assessments, confident and empowered to take action within their own respective spheres of influence.

Table of contents (anticipated)

Target audience

- The book is intended primarily for course use, its primary audience being senior undergraduate students, graduate students and course instructors in English-speaking countries of the OECD. It can also be useful to senior leadership in the homelessness sector (e.g., board members, CEOs and staff).
- The book is intended for courses where homelessness is either the only focus or a major focus. For example, a course on housing and homelessness could benefit from this book. Standalone chapters could also be of great value in various disciplines.
- Some of these courses might be taught outside of the university setting—for example, by the UK-based Chartered Institute of Housing and by its counterparts in other countries, such as CIH Canada.
- The book can be used as either a primary or supplementary text.
- The book is intended to have international appeal, focusing on the English-speaking countries of the OECD: Australia, Canada, New Zealand, the United Kingdom, and the United States.
- Homelessness is widely researched and quickly evolving, as new approaches to both prevention and response are being developed. Much of the book's content will therefore be new even to experienced researchers and practitioners.

All material for this book is available free of charge at https://nickfalvo.com/. Newly-completed chapters will be uploaded throughout the year. The author can be reached at falvo.nicholas@gmail.com.