Barriers to Emergency Shelter Services in Maryland Continuums of Care: A Needs Assessment
Executive Summary

A key objective for the Maryland Interagency Council on Homelessness (ICH) is to "determine best practices and models for providing emergency shelter and shelter diversion, including ensuring the health, safety, and security of shelter residents...and ensuring equal access to protected classes under applicable federal, state, and local civil rights laws."[1] To support this effort, this needs assessment studied current emergency shelter practices throughout Maryland continuums of care (CoCs) and identified the resource gaps and barriers that challenge equitable access and safe environments.

Best Practices: Coordinated Entry and Low Barrier Services
Two best practices for emergency services, according to the Department of Housing and Urban Development (HUD), include coordinated entry (CE) and low barrier or low threshold services. HUD generally "determined that an effective coordinated entry process ensures that people with the greatest needs receive priority for any type of housing and homeless assistance available in the CoC" without "delay[ing] access to emergency services."[2]

HUD includes low barrier emergency services as one characteristic of compliant CE models. Other organizations like the 100,000 Homes Campaign clarified low barrier practices by publishing specific checklists of permissible eligibility requirements. For the purpose of this assessment, I used the 100,000 Homes Campaign's definition of low barrier shelter. Therefore, a low barrier shelter cannot require sobriety or commitment to be drug free, medication for mental illness, participation in religious or drug treatment services, proof of citizenship, identification, a referral from a hospital or police enforcement, and payment or ability to pay.

To assess Maryland CoCs' current practices in relation to these best practices, I conducted a series of interviews with 21 continuum of care leads and staff members covering 14 CoCs.

Findings
CE and low barrier models begin with intake processes that give clients with higher needs priority to emergency services, so I first analyzed CoCs' use of prioritization tools. Half of the CoCs reported prioritizing based on client need for emergency shelter. Among CoCs that used a standardized assessment tool, the characteristics used for sorting differed. Figure One displays the reported prioritization tools across different geographic categories. Figure Two shows the variety of characteristics found in assessment tools. The method for sorting also differed as some CoCs described a numeric scoring system for deciding a client's vulnerability.

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[1] General Assembly of Maryland. 2015. *House Bill 852: Human Resources – Homeless Shelters – Best Practices And Models*. Annapolis, Maryland: Maryland State Archives.
[2] U.S. Department of Housing and Urban Development. 2015. *Coordinated Entry Policy Brief*. Washington, D.C.: HUD Exchange. https://www.hudexchange.info/resource/4427/coordinated-entry-policy-brief/.

Figure One: *Prioritization/Assessment Tools Used for Emergency Shelters by Geographic Category*

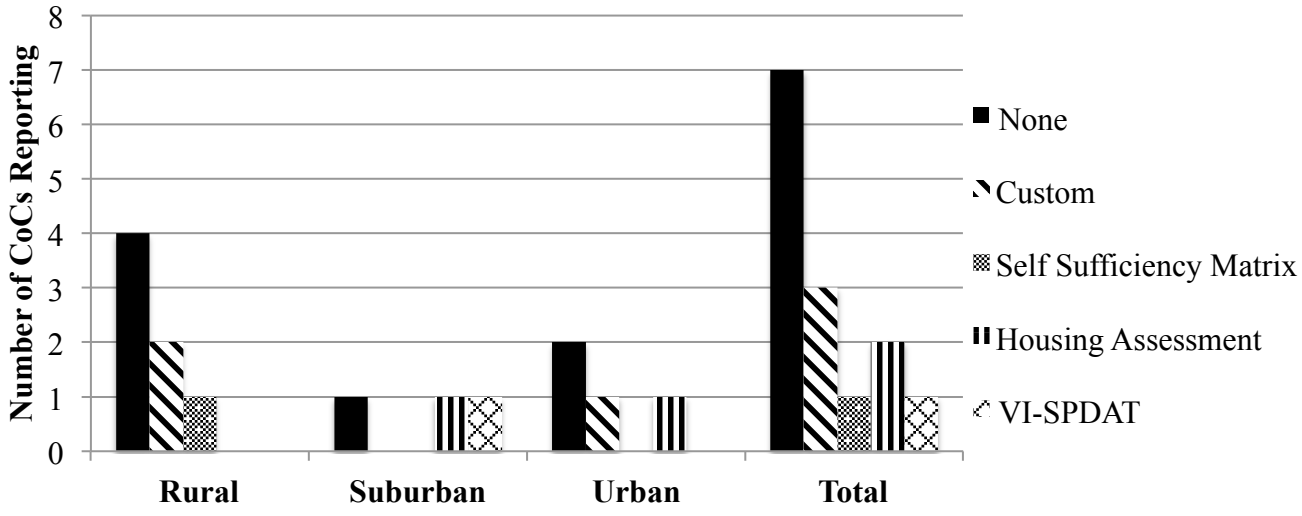
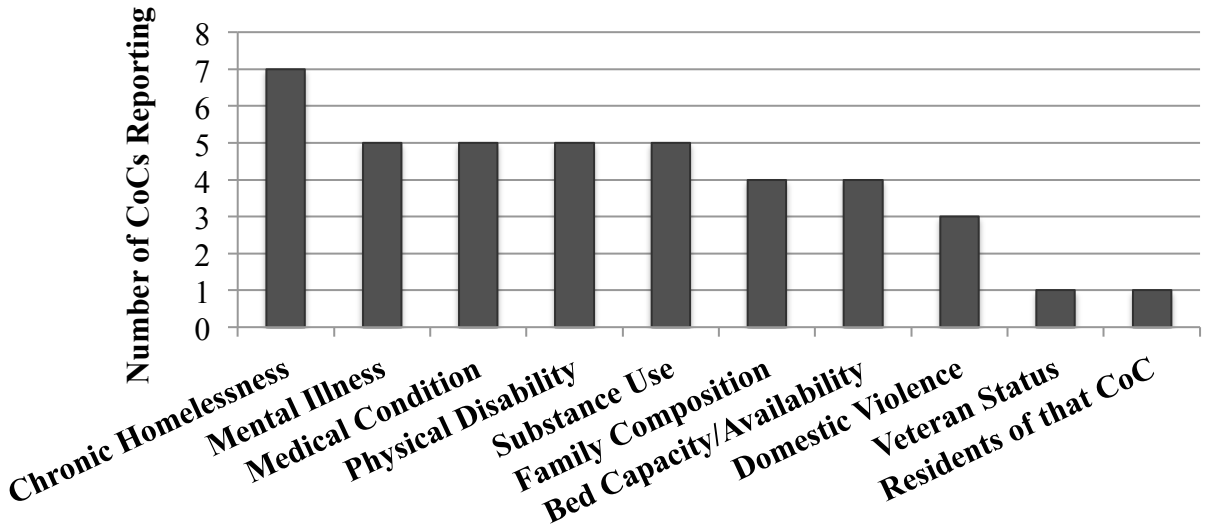


Figure Two: *Needs Prioritized When Using Vulnerability Index*



To find the best practices for keeping clients healthy and safe, the interviews also revealed typical safety concerns and security procedures in emergency shelters. All CoCs described services that established formal rules for behavior that were made clear to clients. Theft and interpersonal violence were the most commonly perceived client safety concerns. Frontline staff members' safety concerns differed from clients, especially when services appeared to be more accessible. CoC leads reported disruptive behavior due to untreated mental illness/substance abuse and a general perception of lack of personal safety as staff members' perceived concerns. Urban CoCs reported using more safety precautions including room/locker checks, security cameras/guards, etc. Finally, some CoC leads reported that clients with multiple housing barriers faced difficulties accessing emergency shelter partially due to the perception and reputation of disruptive behavior.

Maryland policies that did not coincide with CE and low barrier guidelines created barriers and discouraged equitable access. Client advocates described populations like older children in families, clients with physical disabilities, and others as vulnerable to barriers. CoC leads described refusals due to disruptive behavior, untreated mental illness, and active substance use. Physical characteristics of shelters like room layouts, ADA accessibility, and capacity led to some barriers when clients simply could not access appropriate emergency services. Current practices in some reporting CoCs, like sex offender registry/background checks and drug tests showed that shelters have not fulfilled the 100,000 Homes Campaign's eligibility requirement checklist for low barrier entry. Not all CoCs that named these practices used them as a reason for immediate refusal, but those that did created barriers. For rural CoCs specifically, public transportation and programmatic requirements proved to be the most common barriers.

Recommendations

1. Expand the access to low barrier shelter beds statewide so each CoC offers some number of beds for the most vulnerable clients

2. Extend low barrier entry policies used in the cold-weather season to year-round practices

3. Establish a few set-aside beds in each jurisdiction for outreach teams working with the unsheltered to access when those clients agree to shelter

4. Improve staff training, especially using Maryland state online training programs to increase access to Mental Health First Aid, motivational interviewing, Narcan, etc.

5. Hire more professional staff members with clinical or case management backgrounds

6. Improve partnerships with detox providers so clients seeking shelter can access detox services if they agree, prior or while in emergency shelter

7. Increase access to respite beds for clients exiting hospitals or facing sever health issues

8. Increase funding for Assertive Community Treatment (ACT) teams or Mobile Crisis units to help volunteer/frontline staff feel prepared for emergency and safety incidents.

9. Encourage more interagency communication, partnerships, and on site services. For CoCs particularly, create forums to communicate, collaborate, and share best practices

10. Create standards of care relating to low barrier shelters and publish a statewide definition of low barrier emergency services. Conduct a cost projection of these recommendations

Data Needed for Future Assessment and Next Steps

While this report highlighted some resource gaps and barriers that result from current practices in Maryand, more information is needed to fully determine best practices. This necessary data for future studies includes: turn away data; current practices in privately-run emergency shelters; surveys of CoCs policy compared to in depth low barrier checklists specifically; surveys of people experiencing homelessness—particularly those who do not access shelters.