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Assessment #2

Effective Behavioral Health Crisis Care for Individuals Experiencing Homelessness

August 2020

Alexandria, Virginia

Second in a Series of Ten Briefs Addressing—Beyond Beds: Crisis Services

This work was developed under Task 2.2 of NASMHPD's Technical Assistance Coalition contract/task order, HHSS283201200021I/HHS28342003T and funded by the Center for Mental Health Services/Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services through the National Association of State Mental Health Program Directors.

Effective Behavioral Health Crisis Care for Individuals Experiencing Homelessness

July 2020

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Recommended Citation
Arienti, F., Mann-McLellan, A., Martone, K., & Post, R. (2020). *Effective Behavioral Health Crisis Care for Individuals Experiencing Homelessness.* Alexandria, VA: National Association of State Mental Health Program Directors.

EXECUTIVE SUMMARY

The *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit* issued by SAMHSA in February 2020 provides guidelines for a comprehensive and integrated behavioral health crisis network that should exist in communities throughout the country.[1] Using the *National Guidelines* as a framework, this paper explores issues that should be considered in the design and implementation of core crisis system components, with specific consideration of the needs of individuals who experience homelessness.

Homelessness, now recognized as a national public health crisis, is highly correlated with behavioral health conditions.[2, 3] There is significant attention to homelessness through a housing lens, yet solutions to homelessness are complicated by a range of issues, including poverty, housing unaffordability, structural racism, and behavioral health conditions. As discussed in the National Association of State Mental Health Program Directors report, *Bolder Goals, Better Results: Seven Breakthrough Strategies to Improve Mental Illness Outcomes,* ending homelessness is key to achieving the maximum possible success in strengthening behavioral health systems and improving mental health outcomes.[4]

Crisis programs are frequently engaged to respond to homeless individuals who are experiencing a behavioral health crisis. Just as the symptoms of untreated mental illness and substance use disorders (SUDs) often make homelessness more difficult to overcome, lack of stable housing creates extra challenges for engagement in treatment and recovery from behavioral health conditions. Many people who experience homelessness are disconnected from behavioral health systems and providers, and may distrust them. Such individuals often "fall through the cracks," having costly and frequent contacts with shelters, hospital emergency departments, inpatient units, and law enforcement. Once engaged and housed, people with the most significant behavioral health conditions are often better able to access treatment, services, and supports and to remain stably housed.

Local homeless response systems are charged with outreaching and engaging homeless individuals and "meeting them where they're at" by providing for basic needs, including helping to locate emergency shelter, resolving immediate housing crises, and connecting individuals to longer-term housing and supports. Behavioral health crisis programs provide short-term interventions that can play an important role in helping persons with behavioral health conditions who are experiencing homelessness to establish access to long-term treatment and services. Such programs can also proactively collaborate with homeless systems and providers and with law enforcement to ensure cross-system coordination, the use of effective engagement strategies, and meaningful connections — all key steps in breaking the costly cycle and reducing the human toll of homelessness.

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[1] Substance Abuse and Mental Health Services Administration (2020). National guidelines for behavioral health crisis care – a best practice toolkit. Rockville, MD: Substance Abuse and Mental Health Services Administration.

[2] Donovan, S., & Shinseki, E. K. (2013). Homelessness is a public health issue. *American Journal of Public Health*, *103 Suppl 2*(Suppl 2), S180. https://doi.org/10.2105/AJPH.2013.301727

[3] Substance Abuse and Mental Health Services Administration (2013). TIP 55: Behavioral health services for people who are homeless. Retrieved July 15, 2020 from https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4734_literature.pdf

[4] Pinals, D. A., & Fuller, D. A. (2018). Bolder goals, better results: Seven breakthrough strategies to improve mental illness outcomes. Alexandria, VA: National Association of State Mental Health Program Directors.

BACKGROUND

Homelessness, now recognized as a national public health crisis, is highly correlated with behavioral health conditions.[5, 6] There is significant attention to homelessness through a housing lens, yet solutions to homelessness are complicated by a range of issues, including poverty, housing unaffordability, structural racism, and behavioral health conditions. As discussed in the National Association of State Mental Health Program Directors report, *Bolder Goals, Better Results: Seven Breakthrough Strategies to Improve Mental Illness Outcomes,* ending homelessness is key to achieving the maximum possible success in strengthening behavioral health systems and improving mental health outcomes.[7]

Mental illness and SUDs have been consistently associated with housing instability.[8, 9] Numerous studies have demonstrated that behavioral health conditions are a significant risk factor for becoming homeless, as well as a barrier to exiting homelessness.[10] The most recent U.S. Department of Housing and Urban Development (HUD) Annual Homeless Assessment Report (AHAR) to Congress, a point-in-time estimate of the number of sheltered and unsheltered[11] homeless people in the United States, found that 567,715 individuals were experiencing homelessness.[12] Data from the report shows that African Americans, Native Americans, and Hispanics/Latinos remain overrepresented among people experiencing homelessness. Twenty percent of those in the point-in-time count reported they were "severely mentally ill," while nearly sixteen percent reported "chronic substance abuse," though these percentages more than double (55 percent and 42 percent respectively) for those who were unsheltered (211,293). Because 18 percent of the total individuals counted in the AHAR were under age 18, the percentage of those aged 18 years and older who have serious mental illness or who have chronic substance use is likely substantially higher. A review of the literature by the Substance Abuse and Mental Health Services Administration (SAMHSA) cites several studies that estimate between 20 and 50 percent of people who are homeless have serious mental illness.[13] In 2018, SAMHSA's Projects for Assistance in Transition from

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[5] Donovan, S., & Shinseki, E. K. (2013). Homelessness is a public health issue. *American Journal of Public Health*, *103 Suppl 2*(Suppl 2), S180. https://doi.org/10.2105/AJPH.2013.301727

[6] Substance Abuse and Mental Health Services Administration (2013). TIP 55: Behavioral health services for people who are homeless. Retrieved July 15, 2020 from https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4734_literature.pdf

[7] Pinals, D. A., & Fuller, D. A. (2018). Bolder goals, better results: Seven breakthrough strategies to improve mental illness outcomes. Alexandria, VA: National Association of State Mental Health Program Directors.

[8] Kerman, N., Aubry, T., Adair, C. E., Distasio, J., Latimer, E., Somers, J., & Stergiopoulos, V. (2020). Effectiveness of Housing First for homeless adults with mental illness who frequently use emergency departments in a multisite randomized controlled trial. *Administration and Policy in Mental Health*, *47*(4), 515–525. https://doi.org/10.1007/s10488-020-01008-3

[9] Glasheen, C., Forman-Hoffman, V. L., Hedden, S., Ridenour, T. A., Wang, J., & Porter, J. D. (2019). Residential transience among adults: Prevalence, characteristics, and association with mental illness and mental health service use. *Community Mental Health Journal, 55*, 784–797. https://doi.org/10.1007/s10597-019-00385-w

[10] Nilsson, S. F., Nordentoft, M., & Hjorthøj, C. (2019) Individual-level predictors for becoming homeless and exiting homelessness: A systematic review and meta-analysis. *Journal of Urban Health, 96*, 741–750. https://doi.org/10.1007/s11524-019-00377-x

[11] For HUD's definition of sheltered and unsheltered homelessness, see p. 4 of "A Guide to Counting Unsheltered People," by HUD's Office of Community Planning and Development: https://www.hudexchange.info/sites/onecpd/assets/File/Guide-for-Counting-Unsheltered-Homeless-Persons.pdf

[12] U.S. Department of Housing and Urban Development (2019). HUD 2019 Continuum of Care homeless assistance programs homeless populations and subpopulations. Retrieved June 22, 2020 from https://files.hudexchange.info/reports/published/CoC_PopSub_NatlTerrDC_2019.pdf

[13] Substance Abuse and Mental Health Services Administration (2013). TIP 55: Behavioral health services for people who are homeless. Retrieved July 15, 2020 from https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4734_literature.pdf

Homelessness (PATH) program documented the prevalence of co-occurring mental illness and SUDs among persons experiencing or at risk of homelessness at nearly 41 percent (28,945).[14]

Individuals with mental illness or SUDs who experience homelessness are among those most likely to be inadequately connected with and distrustful of behavioral health providers,[15] to have complex needs that cannot be met by any one system, and to cycle continually among shelters, emergency departments, psychiatric and medical inpatient units, and the criminal justice system.[16] Some behavioral health systems fund homeless outreach to engage this specific population. Local homeless systems also provide outreach in order to bring homeless individuals, including those with behavioral health conditions, into engagement with housing and services. However, while some behavioral health providers may be part of a homeless system's provider network, homeless and behavioral health systems operate quite distinctly in most communities. Thus, many homeless systems and providers are not naturally connected with behavioral health crisis systems, nor are they often equipped to manage behavioral health crises among the individuals they serve.

Barriers and Risk Factors Faced by Individuals who Experience Homelessness

In addition to being without a place to live, most persons experiencing homelessness face significant barriers to other positive social determinants of health, a lack of which can precipitate or exacerbate a psychiatric or substance use condition.[17] At a basic level, primary safety and security needs largely go unmet. Lack of food, money, employment, health insurance, clothing, transportation, and access to safe and clean spaces to manage hygiene are all conditions that compromise people's ability to manage their behavioral health.

People who experience homelessness also face a set of common risk factors that are likely to further complicate behavioral health crises. The prevalence of abuse and trauma among both sheltered and unsheltered homeless individuals is significant, particularly among those with co-occurring mental illness and SUDs; research has shown that trauma can be the cause of homelessness just as homelessness can lead to further traumatization.[18, 19] Many studies have also documented a remarkably higher prevalence of suicidal ideation and attempts among people experiencing homelessness as compared to the general population.[20]

Mental illness and SUDs co-exist in a significant portion of those experiencing homelessness, a condition which can be further complicated by untreated physical health conditions. One study found that 78 percent of unsheltered homeless individuals experienced mental health conditions, 75 percent experienced substance use

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[14] Substance Abuse and Mental Health Services Administration (2019). PATH annual report for FY18. Retrieved June 22, 2020 from https://pathpdx.samhsa.gov/Content/preGen/national/23/PATH_Annual_Report_For_FY18.pdf

[15] Hwang, S. & Henderson, M. (2010). Health care utilization in homeless people: Translating research into policy and practice. Agency for Healthcare Research and Quality Working Paper No. 10002. http://gold.ahrq.gov.

[16] Culhane, D. P., Metraux, S., & Hadley, T. (2002). Public service reductions associated with placement of homeless persons with severe mental illness in supportive housing. *Housing Policy Debate, 13*(1), 107-163.

[17] World Health Organization and Calouste Gulbenkian Foundation. (2014). Social determinants of mental health. Geneva: World Health Organization. https://apps.who.int/iris/bitstream/handle/10665/112828/9789241506809_eng.pdf;jsessionid=696605E826D2A544DA6E56CA24F93304?sequence=1

[18] Hopper, E. K., Bassuk, E. L., & Olivet, J. (2010). Shelter from the storm: Trauma-Informed care in homelessness services settings. *The Open Health Services and Policy Journal, 3*: 80-100. https://www.homelesshub.ca/sites/default/files/cenfdthy.pdf

[19] Christensen, R. C., Hodgkins, C. C., Garces, L. K., Estlund, K. L., Miller, M. D., & Touchton, R. (2005) Homeless, mentally ill and addicted: The need for abuse and trauma services. *Journal of Health Care for the Poor and Underserved*, 16(4):615-622. https://doi.org/10.1353/hpu.2005.0091

[20] Ayano, G., Tsegay, L., Abraha, M., and Yohannes, K. (2019). Suicidal Ideation and attempt among homeless people: A systematic review and meta-analysis. *Psychiatric Quarterly, 90*(4), 829–842. https://doi.org/10.1007/s11126-019-09667-8

conditions, 84 percent experienced physical health conditions, and 50 percent experienced all three.[21] The coexistence of these challenges, or "multiple morbidities," place such individuals at greater risk of premature death and overutilization of emergency departments and acute care, in addition to behavioral health crises.

People experiencing homelessness have a higher risk for exposure to infectious diseases due to poor sanitary conditions in unsheltered environments. The current COVID-19 pandemic appears to be affecting people experiencing homelessness at a disproportionate rate, and if exposed, they may be more susceptible to illness or death due to the prevalence of underlying physical health conditions and a lack of reliable and affordable health care.[22] The impact of COVID-19 on crisis response for individuals with behavioral health conditions who are experiencing homelessness is addressed later in this paper.

Individuals with behavioral health conditions who are experiencing homelessness are also more likely to be arrested and incarcerated for low-level crimes than the general population, including public nuisance laws related to loitering, theft, or disturbing the peace.[23] These individuals, in turn, are more likely to return to homelessness and become disconnected from providers.[24]

The Intersection of Homeless Individuals with Behavioral Health Crisis Response Systems

SAMHSA's *National Guidelines for Behavioral Health Crisis Care* provide a framework for a no-wrong-door approach to crisis services that are available to anyone, anywhere, anytime. This core network of services includes 24/7 regional crisis call centers, mobile crisis team services, and crisis receiving and stabilization facilities. According to these SAMHSA guidelines, the absence of an organized crisis services network containing these core elements contributes to the revolving door of repeated hospital admissions, the overuse of law enforcement, and homelessness among individuals with behavioral health conditions.

Crisis programs are frequently engaged to respond to homeless individuals who are experiencing a behavioral health crisis. For some, crisis episodes are a result of uncontrolled symptoms of a mental illness or SUD because the individual cannot access treatment, or their symptoms are such that they are unwilling or unable to engage in treatment. For others, the stress of living on the street or in crowded shelters, exposure to the elements, lack of family connections, poverty, and social supports can precipitate a behavioral health crisis. Whereas a safe apartment can be a therapeutic setting that allows someone to manage a behavioral health crisis in the comfort of home, individuals who are homeless lack many of the basic necessities that are important to coping with a specific episode as well as to long-term recovery.

Behavioral health crisis call centers receive calls directly from homeless individuals, but more often from third parties such as homeless shelter and transitional housing providers, first responders, private businesses, or the general public. Frequently, the contact between homeless individuals and behavioral health crisis programs

[21] Roundtree, J., Hess, N., & Lyke, A. (2019). Health conditions among unsheltered adults. Los Angeles, CA: California Policy Lab. https://www.capolicylab.org/wp-content/uploads/2019/10/Health-Conditions-Among-Unsheltered-Adults-in-the-U.S.pdf
[22] Lima, N. N. R., de Souza, R. I., Feitosa, P. W. G., Moreira, J. L. de S., da Silva, C. G. L., & Meto, M. L. R. (2020). People experiencing homelessness: Their potential exposure to COVID-19. *Psychiatry Research, 288*. https://dx.doi.org/10.1016%2Fj.psychres.2020.112945
[23] The Sentencing Project (2002). Mentally ill offenders in the criminal justice system: An analysis and prescription. Washington, DC: The Sentencing Project. Retrieved on July 15, 2020 from https://www.sentencingproject.org/wp-content/uploads/2016/01/Mentally-Ill-Offenders-in-the-Criminal-Justice-System.pdf
[24] Greenberg, G. & Rosenheck, R. (2008). Jail incarceration, homelessness, and mental health: A national study. *Psychiatric Services*, 59(2)

occurs when mobile crisis response is called to assist a homeless individual in crisis, or through referrals or "drop-offs" by first responders to crisis receiving and stabilization facilities.

Effective crisis programs recognize that providing for basic needs creates an opportunity; they employ the same types of person-centered engagement strategies that are the cornerstone of effective homeless outreach. This includes "meeting people where they're at," providing relief for the most immediate needs, and offering to make connections with resources that the individual both wants and needs in order to access housing, benefits and entitlements, and other services and supports that can address their underlying condition of homelessness. Nevertheless, it is important for crisis programs to retain a focus on resolving behavioral health crises and not assume responsibility for fully resolving homelessness and other social service challenges.

Responding to Homeless Individuals in Crisis: Essential Principles and Practices

Ensure that Crisis System Components are Responsive to the Needs of Homeless Individuals

Effective crisis care for individuals experiencing homelessness requires consideration of the basic needs and unique circumstances they face, along with attention to their clinical and social service needs that extend beyond the brief period during which crisis programs seek to resolve a behavioral health crisis. Here, we present considerations for each of the core components of a crisis response system identified in the SAMHSA guidelines.

24/7 Regional Call Center Strategies

As noted, crisis call centers may be more likely to receive calls *about* individuals who are homeless and experiencing a behavioral health crisis than to hear from homeless individuals themselves. This may be due to the fact that individuals experiencing homelessness are less likely to have access to phones. They may also be distrustful of behavioral health providers due to paranoia, past experiences with civil commitment or law enforcement, or racial discrimination.[25,26,27]

When a crisis call center receives a call either from or on behalf of a homeless individual, screening, assessment, and intervention strategies must be sensitive to a number of situational factors that may be influencing the behavioral health crisis. In addition to clinical considerations, crisis hotline screening and assessment should consider the following when receiving calls either directly from or on behalf of homeless individuals:

- What is the person's housing status — are they currently homeless?
- Is the person with anyone such as a friend or other support?
- What is the person's current location — are they on the street, staying in a shelter, or in an encampment[28]?
- How long has the person been homeless?
- Is the area safe? Are there any public health or safety threats in the area?

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[25] Sweeney, A., Gillard, S., Wykes, T., & Rose, D. (2015). The role of fear in mental health service users' experiences: a qualitative exploration. *Social psychiatry and psychiatric epidemiology*, *50*(7), 1079–1087. https://doi.org/10.1007/s00127-015-1028-z

[26] Institute of Medicine (US) Committee on Health Care for Homeless People (1988). *Homelessness, health, and human needs.* Washington (DC): National Academies Press (US)

[27] National Alliance on Mental Illness. Webpage: Identity and Cultural Dimensions. Retrieved on July 15, 2020 from https://www.nami.org/Your-Journey/Identity-and-Cultural-Dimensions/Black-African-American

[28] To learn more about homeless encampments, see "Understanding Encampments of People Experiencing Homelessness and Community Responses" by HUD's Office of Policy Development and Research: https://www.huduser.gov/portal/sites/default/files/pdf/Understanding-Encampments.pdf

- Does the person have a behavioral health provider, case manager, or housing supports?

Designing and implementing crisis call center strategies that are sensitive to these issues and that collect as much information as possible about a homeless person's individual circumstances, location, and other situational factors can help staff actively engage callers and appropriately triage a response. Good knowledge of specific community programs and resources available to address the needs of homeless individuals may enable call center staff to resolve the immediate issue and divert the individual from further crisis system involvement. In other cases, an individual may be encouraged to come to a facility for further assessment, require connection with mobile crisis response, or be linked to a warm line for ongoing support.

Close collaboration between crisis call centers and programs that are well-equipped or even specifically designed to respond to homeless individuals in crisis can be helpful in beginning to break the cycle of crisis and homelessness for an individual. White Bird Clinic is a Federally Qualified Health Center (FQHC) in Eugene, Oregon that is also a federally funded Health Care for the Homeless Program grantee. White Bird provides a range of health and behavioral health services including a 24/7 crisis hotline, a crisis walk-in clinic, and a 24/7 CAHOOTS (Crisis Assistance Helping Out On The Streets) mobile crisis team. The CAHOOTS team is well-versed in responding to behavioral health crises among homeless individuals; nearly 60 percent of its calls involve unhoused or inadequately sheltered individuals. CAHOOTS is dispatched by White Bird's crisis hotline and the Eugene police-fire-ambulance communications center, and by the Springfield police non-emergency line when calls come in to first responders.[29]

Netcare Access in Columbus, Ohio operates a range of behavioral health crisis services for Franklin County. Individuals, businesses, and other providers can call Netcare's 24/7 crisis hotline to request assistance from a specialized mobile outreach service called ROW ONE that transports approximately 1,500 publicly intoxicated persons per month off the streets to safe locations that include homeless shelters, substance use and mental health treatment centers, crisis centers, and hospitals.[30] The organization also recently began staffing the county's homeless services hotline, so staff have good working knowledge of community resources to prevent and address homelessness.

Mobile Crisis Response Strategies

When mobile crisis response is required for an individual in crisis who is also homeless, teams may be deployed to a variety of locations. Mobile crisis teams must always consider staff safety in responding to crises. Understanding both the various locations and environments involved, as well as any public health concerns such as the current the COVID-19 pandemic or a hepatitis outbreak, for example, is important when responding to a homeless individual.

A community's formal homeless provider network may include programs that offer street outreach, shelter, homeless health care or other safety net clinics, and transitional and permanent supportive housing, along with government-sanctioned homeless encampments, food banks and soup kitchens, and domestic violence programs. Informal settings can include unsanctioned encampments in remote areas and shelters at churches. In many jurisdictions, formal or informal shelters may be seasonal. During the day, many shelters require

[29] White Bird Clinic (n.d.). Crisis Assistance Helping Out On The Streets. Retrieved June 22, 2020 from https://whitebirdclinic.org/wp-content/uploads/2020/06/11x8.5_trifold_brochure_CAHOOTS.pdf

[30] Netcare Access (n.d.). ROW ONE program. Retrieved June 22, 2020 from https://www.netcareaccess.org/services/help-in-a-crisis-adult-youth/reach-out-program/

individuals to vacate the premises, leaving them to spend the day in locations like parks, downtown business areas, libraries, bus or train stations, public transportation, and in remote locations (e.g., under bridges, along trails, and in wooded areas).

Responses to a staffed shelter, an encampment, a train station, a vehicle, or out on the street each have their own circumstances that mobile crisis teams must consider. A homeless individual's location may determine whether the mobile crisis team has communication with a provider who can ascertain specific types of information that will help determine their assessment and response. Crisis programs should work in concert with existing street outreach teams that may have preexisting relationships with individuals. Typically run by homeless service providers, street outreach teams work to engage and stabilize the most vulnerable homeless individuals by placing them into shelter and housing. They provide outreach and care management to homeless people living on the streets who have severe illnesses, and team members may include doctors and nurses.[31] Crisis programs should also understand local shelter requirements, available low-barrier shelter or safe haven options, specific cultural norms at large encampments (i.e. how to enter and exit appropriately and safely), and common safety concerns in shelters or other settings that can exacerbate a behavioral health crisis. They should be familiar with the areas where homeless individuals may congregate, and whether there are site-based or outreach staff present.

In Eugene, CAHOOTS' mobile crisis response team staff are well-known to homeless individuals in the community because White Bird Clinic is also a Health Care for the Homeless provider. The team takes situational and environmental factors into account when responding to homeless individuals in crisis to ensure staff safety, engaging individuals in a non-threatening, trauma-informed manner. Staff wear plain clothes and work to verbally engage individuals while kneeling or using what they call the 'empathy squat', particularly when responding on the streets or in encampments. The team addresses immediate needs such as dehydration and hunger before fully assessing an individual's behavioral health crisis in order to build rapport and engage a person's optimal problem-solving skills.[32] CAHOOTS can directly refer and transport those needing crisis stabilization to another provider who operates those services in the community. CAHOOTS shares a dispatch radio with police and emergency services, allowing it to intervene if the police are called in response to a homeless individual, thereby diverting police contact. Should a homeless individual be considered, based on assessment, to need acute care in an inpatient setting, CAHOOTS can facilitate transport and transition of care at the hospital emergency department (ED) and ensure that the person is triaged as though an ambulance had transported them. Should an individual choose police transport, CAHOOTS stays with the person and similarly facilitates transition of care at the ED. The team is able to resolve most crises by focusing on immediate needs, thereby diverting homeless individuals from further crisis or acute care. The team continues to engage homeless individuals who request their assistance by calling back in to the dispatch line. Peer support workers and case managers are available for warm handoffs from the team when an individual is ready and willing to access housing and other needed treatment and supports.

Baltimore Crisis Response, Inc. (BCRI) operates a range of behavioral health crisis services in Baltimore City, MD; approximately 70 percent of the individuals served are homeless or unstably housed. BCRI's mobile crisis team, composed of a clinician and a nurse who respond in pairs, is accessed through its mobile crisis hotline.[33] The

[31] Boston Health Care for the Homeless Program. Retrieved July 16, 2020 from https://www.bhchp.org/specialized-services/street-outreach

[32] Phone interview with Tim Black, CAHOOTS Operational Coordinator, May 29, 2020

[33] Baltimore Crisis Response, Inc. (n.d.) Mobile crisis team. https://bcresponse.org/our-work/mobile-crisis-team.html

team is often called by shelter or transitional housing providers when a homeless individual is experiencing a crisis that is beyond the staff's ability to effectively manage. The team responds in those settings and is well-trained to be aware of the environment, using trauma-informed and gentle engagement techniques to encourage individuals to come into care. Should an individual be assessed as needing a bed in BCRI's Crisis Residential Unit, this is facilitated and the individual is returned to the homeless provider's setting once stabilized. While BCRI does not utilize a co-responder model, the team is sometimes called to accompany police to homeless encampments to help defuse a crisis or encourage individuals in crisis to come into care.

Crisis Receiving and Stabilization Facility Strategies

Crisis receiving and stabilization facilities offer an alternative to hospital ED assessment and inpatient care for those with more acute needs. They also may have an added benefit for individuals experiencing a behavioral health crisis who are homeless by providing basic necessities, such as food and shelter, which can help mitigate a crisis.

Homeless individuals may walk in on their own or may arrive via mobile crisis team if a crisis cannot be resolved in the setting where the team responded, or after being diverted from the ED. When law enforcement is the first responder to a homeless person in crisis, the person may be dropped off at a crisis facility; programs should have procedures in place that allow officers to quickly return to their duties.[34] RI International's (RI) crisis recovery response center (RRC) model is a crisis receiving and stabilization facility that provides an example of an alternative option to ED drop-offs by law enforcement and others. [35] Its RRC in Peoria, AZ, located 13 miles outside of Phoenix, receives more than 80 percent of its clients, including homeless individuals, via law enforcement drop-offs; whereas another crisis center located in downtown Phoenix receives more walk-ins than police drop-offs due in part to the facility's proximity to the city's homeless population.[36] Staff at crisis facilities should use the same types of trauma-informed and gentle engagement techniques used by mobile crisis teams in engaging homeless individuals, and should also consider how to manage any personal belongings or pets that may accompany an individual.

Effective crisis receiving and stabilization programs accept everyone who comes in the door, and given that they have only hours to resolve a behavioral health crisis and connect individuals with additional care, many operate short-term crisis residential or subacute stabilization beds or can refer people to a program where they can stay longer to stabilize.[37] These and other step-down resources from core crisis system components create much-needed flow in crisis systems, and provide added time for engagement and to link people experiencing homelessness with possible temporary, transitional, or permanent housing and other longer-term resources.

Short stays in these settings allow homeless individuals to continue to be engaged as they begin the process to access housing and other needed treatment, services, and supports, which can take several weeks. Having good contacts for referrals into the local homeless response system, as well as in-house staffing for warm handoffs

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[34] Substance Abuse and Mental Health Services Administration (2020). National guidelines for behavioral health crisis care – a best practice toolkit. Rockville, MD: Substance Abuse and Mental Health Services Administration

[35] RI International (n.d.). RI Crisis Recovery Response Center. Retrieved June 22, 2020 from https://riinternational.com/wp-content/uploads/2015/10/RI-Crisis-RRC-General.pdf

[36] Vestal, C. (2020). As suicide rates climb, crisis centers expand. *Stateline*, an initiative of the Pew Charitable Trust. Retrieved on July 21, 2020 from: https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2020/02/24/as-suicide-rates-climb-crisis-centers-expand

[37] The length of stay in these programs varies from a few days to a couple of weeks to help resolve the immediate behavioral health crisis. They are not designed as a transitional or permanent housing option.

once an individual is ready to transition from crisis care, is an effective combination of strategies for ensuring continued engagement and linkages with longer-term resources.

Netcare Access in Columbus, OH provides step-down care for homeless individuals with mental illness following a stay in its Crisis Stabilization Unit (CSU) through a nine-bed crisis residential program called Miles House funded by the Franklin County Alcohol, Drug and Mental Health system. The program, which also serves individuals coming from psychiatric inpatient units, provides for a stay of up to two weeks, during which individuals can apply for and access transitional housing also funded by the county, or other available housing resources in the community. Peer Specialists work to support homeless individuals as they transition from the CSU back to the community, and provide recovery supports for those who choose a brief stay at Miles House while gaining access to housing and other community resources.

BCRI in Baltimore operates 21 psychiatric crisis beds and 18 SUD treatment beds that offer medically monitored detox; the average length of stay is seven to ten days. State and federal block grant funds support case managers who work to transition homeless individuals to ongoing treatment, housing, and other supports post-care. BCRI is able to effectively connect homeless individuals with housing once they are stabilized through direct partnerships with transitional and permanent housing providers. Case managers actively work to make referrals to these providers and to connect individuals with benefits and entitlements. The program provides individuals with 30 days' worth of medications as a bridge while they wait for prescribing appointments, or in the event their Medicaid has lapsed, a service that makes housing providers more receptive to warm handoffs following crisis care.

Incorporate Interventions that Effectively Engage Homeless Individuals

In addition to the above considerations, effective crisis response with individuals who are experiencing homelessness requires that crisis programs incorporate into crisis service design and delivery evidence-based and best practice interventions that are responsive to the population's needs, along with workforce development and training for staff on implementing these interventions.

Effective crisis service delivery with homeless individuals means moving beyond crisis response that is disposition-focused to incorporating more resolution-oriented practices. This involves being *person-centered* in terms of service delivery approach, collaborating with the individual on solutions. Such interventions recognize the individual in crisis as the expert in identifying the immediate needs to be resolved. By taking the time to establish rapport and understand the person's overwhelming situation, crisis program staff can help mitigate the behavioral health crisis and facilitate access to resources that can help address the person's homelessness, but which they may have been hitherto unable to navigate.

Motivational interviewing (MI) is a strengths-based, client-centered engagement intervention that enhances motivation to change and resolves ambivalence. It is a particularly effective approach for working with long-term homeless individuals with mental illness and/or SUDs who have not responded well or have been resistant to more traditional forms of treatment engagement. MI is frequently used by homeless outreach workers and other homeless system providers to engage individuals in a sensitive and nonaggressive manner. Tenets of MI that can inform crisis program staff response to individuals experiencing homelessness include:[38]

[38] Substance Abuse and Mental Health Services Administration (2010). Spotlight on PATH practices and programs: Motivational interviewing. Retrieved on June 22, 2020 from https://www.samhsa.gov/sites/default/files/programs_campaigns/homelessness_programs_resources/path-spotlight-motivational-interviewing.pdf

- Asking permission to talk with individuals instead of assuming they want to talk
- Finding a safe space for the individual to talk
- Learning what is important to the individual and addressing their immediate needs
- Finding out what services the individual wants and has the motivation to pursue
- Refraining from pushing individuals into services they do not want
- Exploring ambivalence using open-ended questions and reflective statements

Trauma-informed care is included in the SAMHSA guidelines as a core principle. Because so many studies have shown high prevalence rates of trauma among persons in the behavioral health and homeless system, effective crisis response programs assume that individuals presenting will have personal experiences with prior and/or more recent trauma. During a crisis, such experiences may result in an exacerbation of one's behavioral health condition and affect people's problem-solving capacity. Trauma-informed approaches are particularly crucial with individuals experiencing homelessness due to high trauma rates that may be both a risk factor and a cause of homelessness.[39] Poorly designed crisis response that is not trauma-informed can have negative effects and cause more trauma and distrust.

Culturally responsive services are critical to engaging populations that are disproportionately represented within a community's homeless population. To the extent possible, staff should be representative of the racial, ethnic, and gender identities of a community's population, inclusive of those experiencing or at greatest risk of homelessness, and competently trained and supervised in culturally responsive practices. Attending to these considerations will better prepare staff to address racial and other disparities that may be factors in people's behavioral health crises. Designing services to be culturally responsive promotes the ability of staff to build the trust, rapport, and continuous engagement required over long periods of time to fully engage individuals experiencing homelessness.

SAMHSA's crisis care guidelines recommend the **inclusion of peers as crisis program staff**. Similarly, the homeless system frequently includes individuals who have previously been homeless in various staff roles.[40] Because homelessness is prevalent among individuals that crisis programs encounter, programs should employ individuals who have lived experience with mental illness, SUDs, and homelessness in each of their core crisis services. Peers with these qualifications can be particularly effective in engaging those who are experiencing long-term homelessness and who may be reluctant to engage with behavioral health professionals or first responders. Peers can also be very effective at helping to transition and link individuals to follow-up care and resources in the community post-crisis. RI International's peer-operated "Living Room" programs ensure that participants are paired with a team of Peer Support Specialists in recovery.[41] Each guest is encouraged to work with the team and empowered to develop their own recovery plan. RI employs more than 500 peers who have experience with addiction and/or homelessness in addition to mental illness.[42]

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[39] European Federation of National Organisations Working with the Homeless (2017). Recognising the link between trauma and homelessness. Retrieved on July 16, 2020 from https://www.feantsa.org/download/feantsa_traumaandhomelessness030734712190529468107 38.pdf

[40] Barker, S. L., & Maguire, N. (2017). Experts by Experience: Peer support and its use with the homeless. *Community Mental Health Journal*, *53*(5), 598–612. https://doi.org/10.1007/s10597-017-0102-2

[41] RI International (n.d.). RI's crisis services improve care and reduce costs. Retrieved on July 21, 2020 from: https://riinternational.com/crisis-services/

[42] Covington, D. (2016). Yes, I can! What if we all embraced recovery? RI International blog. Retrieved on July 21, 2020 from: https://riinternational.com/2016/09/

The ability of staff to **respond to co-morbid medical conditions** is particularly critical in crisis response with homeless individuals given high rates of tri-morbidity in this population. White Bird Clinic's CAHOOTS mobile response team pairs behavioral health clinicians with a nurse or EMT and also has access to other health care services thanks to its status as an FQHC and Health Care for the Homeless provider. In addition to psychiatrists and an addiction medicine physician, Baltimore Crisis Response, Inc. has in-house nursing staff who can manage both physical and behavioral health conditions, including administration of medications, enabling the program to care for homeless individuals who might otherwise require a hospital setting to receive needed health care.

In addition to ensuring **workforce development and training** specific to the interventions above, crisis programs should incorporate training for staff on a range of topics, including population-specific issues and challenges related to homelessness, SUDs, chronic health conditions, and co-occurring disabilities (e.g., developmental disabilities). Staff training should facilitate clinical assessments that consider these needs. Further, while the primary role of crisis programs is to resolve an immediate behavioral health crisis, staff should receive basic training on the range of social service needs that homeless individuals have and how these resources are accessed in the community in order to refer and link individuals as necessary. This includes homeless housing programs and services offered by the local homeless Continuum of Care (CoC), Health Care for the Homeless and other safety net health clinics, mental health and substance use treatment providers, peer and recovery support programs, SOAR[43] or other programs that assist with accessing benefits and entitlements, and programs that provide food assistance, to name a few.

Proactively Collaborate with Homeless Housing Systems and Law Enforcement

Effective behavioral health crisis response for individuals experiencing homelessness also calls for proactive collaboration with homeless housing systems and providers and with law enforcement to ensure effective handoffs and connections to those who can help address the underlying causes of people's homelessness. Such cooperation also serves to mitigate responses that might otherwise be harmful to a homeless individual or escalate their crisis. Collaboration strategies can include:

- Implementing training across systems to understand the resources and roles of each, and to encourage best practices
- Establishing procedures for information- and data-sharing and for warm handoffs
- Formalizing partnerships and roles through memorandums of understanding (MOUs) and other opportunities for formal cross-system involvement

Strategies for Working with Homeless Systems and Providers

Training opportunities. Crisis and homeless systems and providers each have expertise that can be leveraged to improve outcomes for people experiencing homelessness, and should engage in cross-training so each is knowledgeable about what the other has to offer. In some communities, behavioral health providers may be part of the homeless provider network, but this is often not the case. Some homeless service agencies may have very little contact or coordination with behavioral health providers, and may not be aware of how to access crisis services other than by calling 911. Crisis providers can train homeless providers on the services a crisis program can provide, when and how to call crisis services, when and how it can respond, and limitations to its scope or resources. Crisis providers can also train homeless providers with basic knowledge on recognizing the

[43] SSI/SSDI Outreach, Access, and Recovery (SOAR) helps states and communities increase access to Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) benefits for people who are experiencing or at risk of homelessness and have a serious mental illness, medical impairment, and/or a co-occurring substance use disorder.

signs of a behavioral health crisis, including those associated with substance use and overdose, and de-escalation strategies.

Likewise, homeless systems and providers can train crisis system providers on effective approaches for working with homeless individuals, with an emphasis on meeting basic needs and strategies to develop rapport. Crisis providers should also learn the basics of the local CoC, its scope and role, and the process by which its resources are prioritized and accessed by homeless individuals. Most planning and funding for homelessness is done at the local community level through the HUD CoC process. HUD awards funding for emergency shelter, affordable housing, and services such as outreach to assist those experiencing homelessness through competitive grants to providers who are part of local CoCs which are typically administered at the county or city level.[44] Crisis programs not familiar with their local CoC and its provider network can inquire with the contacts in their community.[45]

Crisis programs should have a basic understanding of their community's approach to the prioritization of HUD-funded housing resources available through the CoC. While other sources of affordable housing administered by housing authorities, private developers, or state- and locally-funded programs may be accessed by individuals experiencing homelessness, HUD's CoC program is the largest form of targeted federal housing assistance dedicated to resolving homelessness. Demand for these limited homeless housing resources far exceeds capacity in each community, so CoCs use a process known as coordinated entry (CE) to prioritize resources for those with the greatest vulnerabilities. While it is outside of most crisis programs' role and resources to assist homeless individuals in accessing permanent housing, crisis providers should become familiar with the basics of their CoC's CE system and policies, which are often posted publicly on the CoC's website, and include:

- *Priority populations:* The populations that are prioritized most frequently for a CoC's housing resources. Often, priority populations include those who have been homeless the longest, or those with the greatest vulnerability to adverse outcomes while living unsheltered. Psychiatric crises and behavioral health conditions are often taken into account.
- *Access Points:* CE systems typically have one or more access points where people experiencing homelessness can be assessed for CoC housing resources. These access points are often published online and distributed widely to community stakeholders. In some communities, behavioral health providers, health care providers, and hospitals have volunteered to become access points in a community's CE system due to the overlap in populations served. Access points typically offer problem-solving assistance to rapidly resolve a homeless crisis, and assessment and referrals to potential housing options for which an individual may qualify.

Information sharing and warm handoff. If the crisis program is called to respond to a homeless individual, the program should engage homeless providers to share information on the best ways to contact homeless outreach teams, shelter staff, or case managers in order to garner as much information as possible to support crisis triage and response, and to facilitate a transition back into services as applicable once the individual is stabilized.

[44] States also manage larger geographic areas through Balance of State CoCs.

[45] CoC contact information is available on the HUD Exchange at: https://www.hudexchange.info/grantees/contacts/?params=%7B%22limit%22%3A20%2C%22sort%22%3A%22%22%2C%22order%22%3A%22%22%2C%22years%22%3A%5B%5D%2C%22searchTerm%22%3A%22%22%2C%22grantees%22%3A%5B%5D%2C%22state%22%3A%22%22%2C%22programs%22%3A%5B3%5D%2C%22coc%22%3Atrue%7D##granteeSearch

Each CoC is required to input homeless services data into a Homeless Management Information System (HMIS). At a minimum, HMIS captures data on homeless services usage; however, many communities have customized their own HMIS to collect additional data points such as where people are residing (i.e. encampment location, exact emergency shelter), vulnerability factors an individual has experienced that may contribute to prolonged homeless episodes, collateral contacts, and even touches with medical or corrections systems. Crisis programs could benefit from entering into data-sharing arrangements (and corresponding data-sharing agreements that address HIPAA, 42 CFR Part 2, and other issues) with homeless service providers to access important information that could help facilitate crisis response. Similar collaborations have been developed between health care and homeless service providers to integrate HMIS with electronic medical health records to provide seamless intake, assessment, and referral of individuals between systems of care. Data-sharing collaborations such as these could assist crisis services to quickly locate participants, as well as tap into collateral contacts that can be leveraged to create sustainable warm handoffs from crisis services.

Recognizing opportunities for warm handoffs from crisis programs to homeless system providers who are most able to assist, and ensuring that such handoffs are accomplished, can provide meaningful and lasting connection to resources that go beyond resolving the immediate crisis, and can also mitigate the risk of future crises. Homeless systems should ensure that crisis programs have contact information for homeless provider staff who can be leveraged for warm handoffs. In each community, the staff who can assist in finding permanent housing, refer to community-based treatment and supports, maximize income options, and in some cases provide ongoing behavioral health treatment as a part of the services will be different. They may include case managers or peer support workers/navigators embedded in street outreach teams, emergency shelters, and supportive housing programs. As previously noted, crisis programs like BCRI and CAHOOTS use flexible funds to support their own staff who link people who are willing but not otherwise engaged with housing, treatment, and supports. Staff such as these in either system can be important connectors between the two.

Finally, some communities have incorporated case conferencing strategies into their efforts to end homelessness, bringing together stakeholders to create tailored pathways to permanent housing for homeless individuals who are a community's most vulnerable or who are experiencing long-term or chronic homelessness.[46] Some crisis providers join case conferencing when their caseload significantly overlaps with the community's homeless population in an effort to create care plans with service providers that mitigate the risk of continued behavioral health crises.

Formalizing partnerships and cross-system involvement. Many partnerships and referral processes begin informally through relationships built over time. Often these provider-level arrangements are formalized through MOUs that establish clear roles and responsibilities for each entity. Such partnerships can lead to broader knowledge and collaboration at the systems level where MOUs can be created as well.

In some communities behavioral crisis providers like the CAHOOTS mobile response team have MOUs with the CoC or with the entities that manage their CoC's CE system so they can refer homeless individuals to be assessed and triaged for housing resources. While these types of referrals may not be made directly by crisis program staff, they are an important step in the process of connecting individuals to housing resources that can support long-term recovery. Crisis programs should also consider building relationships and establishing MOUs with homeless outreach teams as the entities that are often most familiar and engaged with homeless individuals in a

[46] To learn more about chronic homelessness as defined by HUD, see "Here's What You Need to Know about HUD's New Chronic Homelessness Definition" by the National Alliance to End Homelessness: https://endhomelessness.org/heres-what-you-need-to-know-about-huds-new-chronic-homelessness-definition/

community. Crisis service providers can participate more formally in their local homeless response system by becoming a homeless system provider as well. For example, Netcare Access is the behavioral health crisis system provider in Franklin County, OH and also operates the county's homeless services hotline, an arrangement which has opened the door to further collaborations with the homeless response system.

Crisis providers can also seek to become a member in their CoC's governing body. HUD has charged its nearly 400 CoCs across the country to convene a diverse set of community stakeholders, including those from other systems of care that frequently have contact with homeless individuals. Membership is often open, but each CoC has its own process for becoming a member. Benefits of membership in a CoC's governing body include helping to inform the deployment of resources that are mutually beneficial to multiple systems of care. Many CoCs have strategic plans to actively guide their efforts and resources to address homelessness, and behavioral health crisis service providers can identify mutually beneficial goals to work toward through CoC involvement.

Strategies for Working with Law Enforcement

Law enforcement is often the first to receive the call in response to a homeless person who is experiencing a behavioral health crisis. Thus, good planning and coordination between behavioral health crisis systems and law enforcement is essential to properly de-escalate the situation as necessary, engaging individuals and diverting them from unnecessary justice system involvement.

Training opportunities. As noted above, training can be beneficial to encourage the adoption of best practices in responding to homeless individuals experiencing a behavioral health crisis. Many communities offer specialized Crisis Intervention Training (CIT) to a subset of their emergency responders who can be deployed when responding to 911 or crisis line calls where law enforcement is required. CIT-designated first responders are trained to be familiar with available local crisis response resources and protocols for securing additional services. The CAHOOTS mobile crisis team regularly collaborates with law enforcement, a relationship which also involves CIT and Mental Health First Aid training for officers. BCRI similarly offers CIT training for local law enforcement, in addition to offering a training module on 'trauma-informed policing." BCRI invites officers to visit its crisis facility to talk with consumers about the experiences that have contributed to their conditions in order to encourage more collaborative problem-solving in response to the crises they encounter.

Information-sharing and warm handoffs. If law enforcement is the first to respond to a homeless individual experiencing a behavioral health crisis, they should be able to contact a crisis call center for support, rely on a mobile crisis team to respond, and have the capability to bring a person to a crisis receiving facility to divert individuals from the criminal justice system through brief warm handoffs so that officers can get back to their work. In an interview included in the SAMHSA *Guidelines*, Nick Margiotta (president of Crisis Service Solutions in Phoenix, AZ) discusses this element as being critical to law enforcement buy-in and collaboration with crisis services.[47]

Some communities have developed specialized consortiums to coordinate between service providers and first responders on appropriately triaging people experiencing homelessness when a psychiatric or substance-use-related crisis occurs. These consortiums often focus on frequent utilizers of emergency services and consist of law enforcement, EMS, hospitals, managed care organizations, street outreach, and other homeless service providers. Client-level interventions are developed by these groups with the aim of reducing the use of emergency services, acute care, and jail by leveraging partnerships and existing community-based services.

[47] Substance Abuse and Mental Health Services Administration (2020). National guidelines for behavioral health crisis care – a best practice toolkit. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Solutions developed include strategies for law enforcement to divert individuals from jail to available shelter or detox beds, and for EMS to identify frequent users of the service who may benefit from more stable housing.

Formalizing partnerships and cross-system involvement. The CAHOOTS mobile crisis team was designed as an alternative to police intervention in response to mental health crises in the community. Thus, its partnership with local law enforcement is formalized through an MOU and the two work together closely to divert individuals in crisis, including those experiencing homelessness, from police contact as much as possible. The CAHOOTS team responds to calls involving individuals with behavioral conditions that come in through 911 as well as the police non-emergency line. The team also works to actively find and engage those identified by patrol officers for quality of life offenses to divert them from further justice system involvement.

BCRI works formally with the Baltimore Police Department on two programs that regularly interface with individuals in behavioral health crisis who may also be experiencing homelessness. Its Crisis Response Team (CRT) pilot program pairs a CIT-trained police officer with a licensed clinical social worker to jointly respond to police calls involving individuals experiencing a behavioral health crisis. Officers receive training and support in order to safely engage these individuals, improving outcomes for all involved. The second collaboration involves diverting individuals who are homeless and have been identified by police for certain low-level offenses to the Law Enforcement Assisted Diversion (LEAD) program in lieu of arrest. LEAD case managers engage these individuals by meeting basic needs for food, clothing, and housing prior to addressing treatment needs. Nationally, the LEAD program has shown promising outcomes for individuals who are homeless and in need of housing.[48]

COVID-19 Considerations for Responding to Individuals Experiencing Homelessness

Behavioral health crisis programs will need to continue to adapt to the effects of the COVID-19 pandemic and related economic crisis, with unique considerations for persons living with behavioral health disorders who are experiencing homelessness. In many communities across the country, homelessness was growing prior to the pandemic, and there could be increases in homelessness ahead, as lost incomes are likely to result in more evictions despite legislative efforts to prevent people from losing housing. Coupled with increased need for behavioral health services against strained or decreasing services, crisis response programs will likely experience more encounters with individuals who are experiencing or at risk of homelessness, particularly with racial and ethnic minority groups disproportionately affected by the pandemic[49] and the resulting economic crisis.[50]

Crisis programs should be aware that many individuals who are homeless have nowhere to shelter in place, quarantine, or isolate without public health disaster response resources. Those living in encampments are subject to social distancing protocols placed upon them by public health, public safety, and homeless service providers that interfere with outreach, engagement, and service delivery, even while reducing viral spread. Providers in emergency homeless shelters have also been significantly impacted and are having to implement new and potentially stressful safety protocols that create physical distance between the individuals being served, staff, and volunteers. These new disease management measures, which may also prohibit homeless

[48] Collins SE, Lonczak HS, Clifasefi SL. (2017). Seattle's Law Enforcement Assisted Diversion (LEAD): Program effects on recidivism outcomes. *Eval Program Plann*. 64:49-56. doi:10.1016/j.evalprogplan.2017.05.008

[49] Centers for Disease Control and Prevention. COVID-19 in racial and ethnic minority groups. Retrieved on July 16, 2020 from https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html

[50] Brown, S. (2020). The COVID-19 crisis continues to have uneven economic impact by race and ethnicity. *Urban Wire,* blog of the Urban Institute. Retrieved on July 16, 2020 from https://www.urban.org/urban-wire/covid-19-crisis-continues-have-uneven-economic-impact-race-and-ethnicity

individuals from accessing their friends and other naturally occurring support systems, may further exacerbate behavioral health conditions and have a lasting impact for years to come.

Early in the pandemic, shortages of personal protective equipment (PPE) inhibited crisis mobile response teams from responding to many calls and often required a default to crisis hotline and telehealth triage strategies, especially with callers such as first responders and providers. Access to PPE is critical for mobile crisis teams when working with individuals who are homeless due to high rates of infection in this population. In Boston, nearly 40 percent of homeless individuals tested positive for the virus at one large shelter.[51] Responding to homeless shelters may require mobile teams to engage an individual just outside of the shelter. Even in open air encampments, living conditions may result in tight spaces that impede physical distancing standards, and mobile teams must have policies and strategies in place to address these scenarios.

Several communities have established temporary housing and temporary quarantine sites in hotels or other settings for individuals who are homeless.[52] Crisis providers should explore ways to collaborate with, respond to, support, and utilize these sites for mobile crisis response, crisis stabilization, and temporary crisis residential support.

Some crisis stabilization and residential programs have had to decrease capacity in order to implement physical distancing protocols. This can limit access to step-down options from crisis care that homeless individuals may need as they are coming out of a behavioral health crisis and being connected with longer-term resources to resolve their homelessness. Access to transitional and permanent housing programs may also be limited for similar reasons during the pandemic which may impact flow through some crisis systems for people experiencing homelessness who are interested in accessing these resources.

State and local policymakers and payers must ensure that behavioral health crisis programs retain capacity in order to respond to crises rather than default to law enforcement or other first responders. Crisis hotlines and mobile teams must be able to respond to calls in a timely manner. For mobile teams and crisis receiving facilities, this also requires an adequate supply of PPE.

CONCLUSION

Effective crisis response for people experiencing homelessness requires attention to each individual's unique clinical and social service needs, as these can further complicate a behavioral health crisis. The current pandemic and attention to structural racism have increased the visibility of the challenges in working with individuals who are homeless and experiencing behavioral health conditions. By collaborating with homeless system providers, behavioral health crisis programs can ensure that their screening, assessment, and intervention strategies are sensitive to these and other situational and environmental factors, thereby informing an appropriate crisis response for individuals who are experiencing homelessness and helping to ensure the safety of crisis program staff.

Beyond individual crises, behavioral health crisis programs have a unique opportunity to facilitate access to resources that can help resolve homelessness among persons with behavioral health conditions. Evidence-based

[51] Baggett, T., Keys, H., Sporn, N., Gaeta, J. (2020). Research Letter: Prevalence of SARS-CoV-2 infection in residents of a large homeless shelter in Boston. *Journal of American Medicine*, *323*(21)

[52] University of Wisconsin, School of Medicine and Public Health, Department of Family Medicine and Community Health (2020). Responding to COVID-19: Operational guidance and considerations. Retrieved on July 16, 2020 from https://www.fammed.wisc.edu/files/webfm-uploads/documents/covid19/operational-guidance.pdf

and best practice interventions shown to be effective with homeless individuals who may be unable or unwilling to engage should be incorporated into crisis services design and delivery, including the use of peer specialists, and supported through workforce development and training. Interventions should meet individuals experiencing homelessness "where they're at," not only providing relief for immediate and basic needs during a crisis, but making connections with housing and longer-term resources that can address their underlying condition of homelessness.

To ensure continued engagement and linkages with longer-term resources, it is important to have both good contacts for referrals into the local homeless response system and in-house crisis program staffing for warm handoffs once an individual is ready to transition from crisis care. Peer specialists with lived experience of homelessness and/or mental health and addiction challenges, in addition to case managers, can work to transition individuals back to the community, making referrals as needed.

Behavioral health crisis programs should not be relied on to resolve homelessness and other social service challenges; however, step-down resources from crisis systems are a critical "back door" for homeless individuals as they come out of behavioral health crisis and seek longer-term resources. Access to short-term residential, subacute crisis stabilization beds, or to other programs where homeless individuals can stay longer to stabilize, allows them to stay engaged as they begin the process of accessing housing and other needed treatment, services, and supports.

Crisis programs should proactively collaborate with homeless systems and providers and with law enforcement — both to ensure effective handoffs and connections with those who can assist a homeless individual longer-term, and to avoid responses that might be harmful to them or escalate their crisis. Cross-system training should encourage understanding of each system's respective resources and roles, and should encourage best practices. Protocols should be established for information-sharing and warm handoffs to inform crisis triage and response and to facilitate smooth care transitions for the individuals served. Informal partnerships and collaborative relationships should lead to more formal ones, including broader systems-level efforts that recognize people with behavioral health conditions who are experiencing homelessness as a commonly encountered population requiring a coordinated response to break the cycle of crisis and homelessness.

This working paper was supported by the Center for Mental Health Services/Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services.