NEW YORK STATE | Office of Mental Health

Safe Options and Person-Centered Approaches to Addressing Homelessness

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Safe Options Support (SOS) Program: CTI Teams

Safe Options Support (SOS) Teams

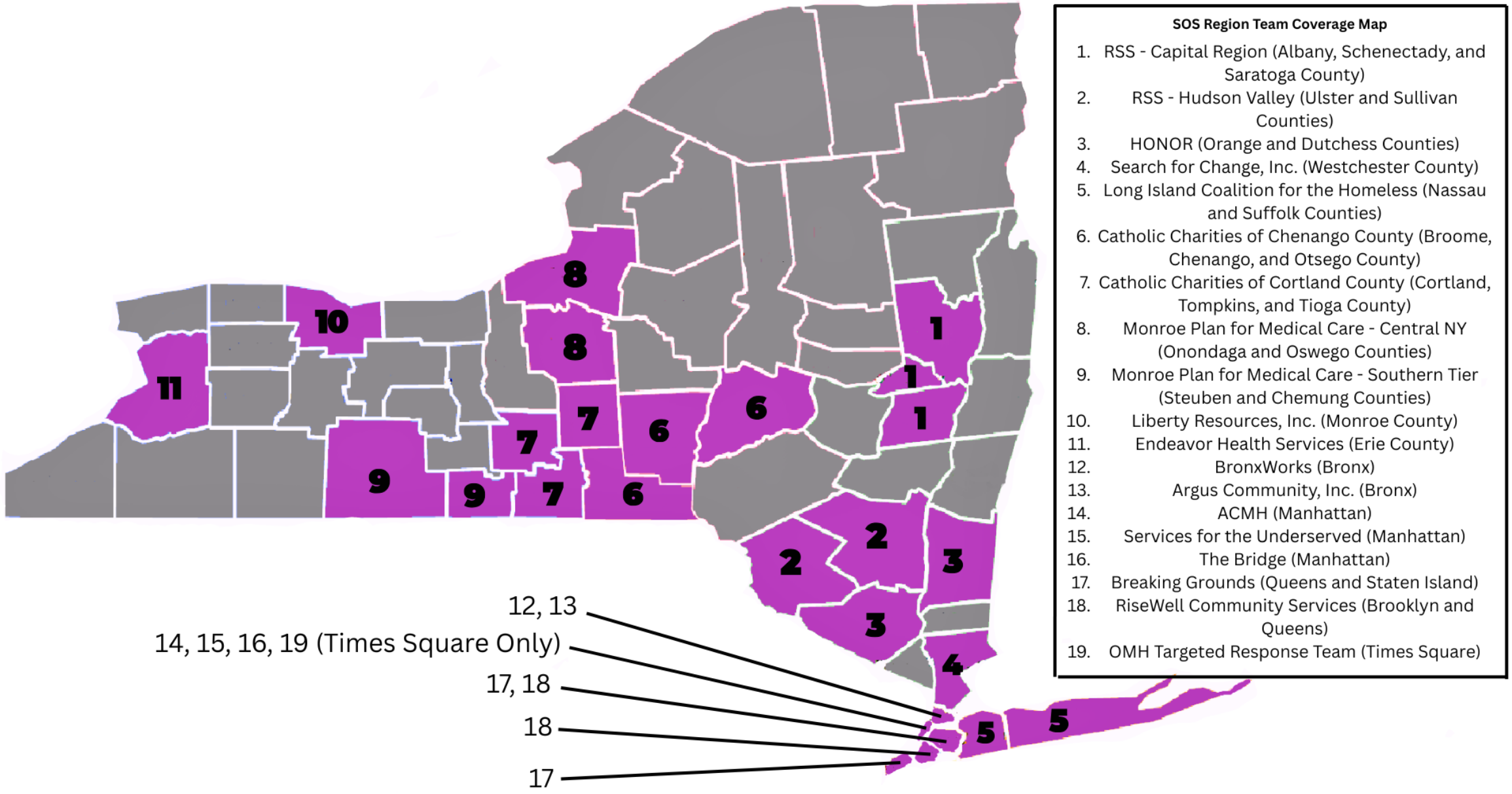
- Multidisciplinary teams using Critical Time Intervention approach to provide intensive outreach, engagement, and care coordination services to unhoused individuals until stably housing (approx. 9-12 months).

- Each team has 9-12 members when fully staffed. Teams are composed of licensed clinicians, care managers, and peer specialists. NYC Teams also include a registered nurse.

- 26 SOS CTI Teams & 3 Overnight Outreach Teams currently active statewide; 2 additional teams launching this summer.

Safe Options Support (SOS) Teams

- Program does not currently bill Medicaid (fully State-aid funded); providers receive funding for staffing, operational costs, and wrap-around dollars.
- Fiscal model allows for greater flexibility by programs to best meet the needs of each region.
- Wrap-around dollars can help meet immediate needs and support community inclusion post-housing placement.



SOS Region Team Coverage Map

1. RSS - Capital Region (Albany, Schenectady, and Saratoga County)
2. RSS - Hudson Valley (Ulster and Sullivan Counties)
3. HONOR (Orange and Dutchess Counties)
4. Search for Change, Inc. (Westchester County)
5. Long Island Coalition for the Homeless (Nassau and Suffolk Counties)
6. Catholic Charities of Chenango County (Broome, Chenango, and Otsego County)
7. Catholic Charities of Cortland County (Cortland, Tompkins, and Tioga County)
8. Monroe Plan for Medical Care - Central NY (Onondaga and Oswego Counties)
9. Monroe Plan for Medical Care - Southern Tier (Steuben and Chemung Counties)
10. Liberty Resources, Inc. (Monroe County)
11. Endeavor Health Services (Erie County)
12. BronxWorks (Bronx)
13. Argus Community, Inc. (Bronx)
14. ACMH (Manhattan)
15. Services for the Underserved (Manhattan)
16. The Bridge (Manhattan)
17. Breaking Grounds (Queens and Staten Island)
18. RiseWell Community Services (Brooklyn and Queens)
19. OMH Targeted Response Team (Times Square)

Eligibility & Enrollment

Eligibility & Enrollment

- Individuals must be unhoused or in an emergency shelter setting to be eligible for SOS services. In NYC, special focus on individuals who are street homeless or subway-dwelling.

- A diagnosis of serious mental illness or substance use disorder is not required for enrollment; however, priority will be given to individuals with behavioral health needs.

Eligibility & Enrollment

- SOS Teams have developed referral systems that best meet the needs of their communities, including brief referral forms and toll-free numbers to request outreach response.

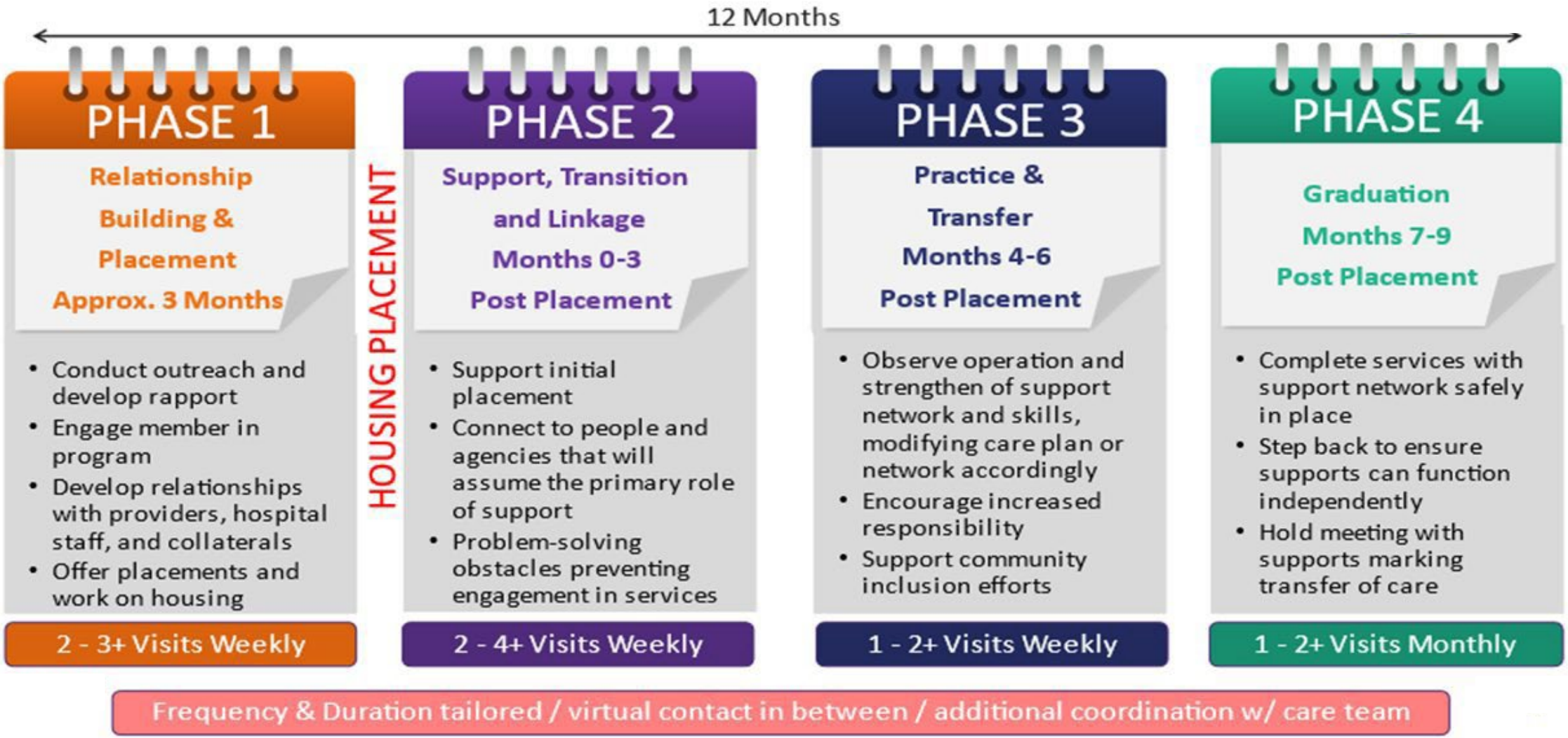
- SOS referrals can be made by hospitals, community stakeholders, agencies, family, other supports. Upon receiving a referral, SOS Teams respond within 24-48 hours to initiate outreach efforts.

Safe Options Support Model

What is Safe Options Support?

- A time-limited care transitions model that utilizes a number of evidenced-based interventions:
  - Critical Time Intervention (CTI)
  - Harm Reduction
  - Recovery Orientation
  - Motivational Interviewing
  - Peer Support
- A mobile/community-based multidisciplinary team supporting a member's journey from homelessness into housing
- An intervention that impacts continuity of care and community integration by actively building and strengthening the member's network of support
- An adaptable model that can be applied to different settings, populations, and cultures

SOS Multi-Phased Model



Services Offered Through SOS Outreach

- The menu of services that can be provided during outreach is limited only by imagination and resources. Some potential services commonly offered include:

Engagement

- Initiating conversation
- Offering a sandwich, coffee, or water
- Offering a blanket, socks, shoes, hats, gloves, or other clothes
- Offering hygiene articles, sunscreen, first aid items

Information & Referral

- Offering information about available services in the community
- Linking to shelter or other housing options or transition placement
- Refer to sites that offer food, clothing, shower, laundry, or other basic needs

Direct Services

- Connecting with Dept of Social Services
- Obtaining IDs and applying for entitlements
- Case management
- Crisis intervention including links to emergency or hospital care
- Advocacy and assistance navigating the systems of care

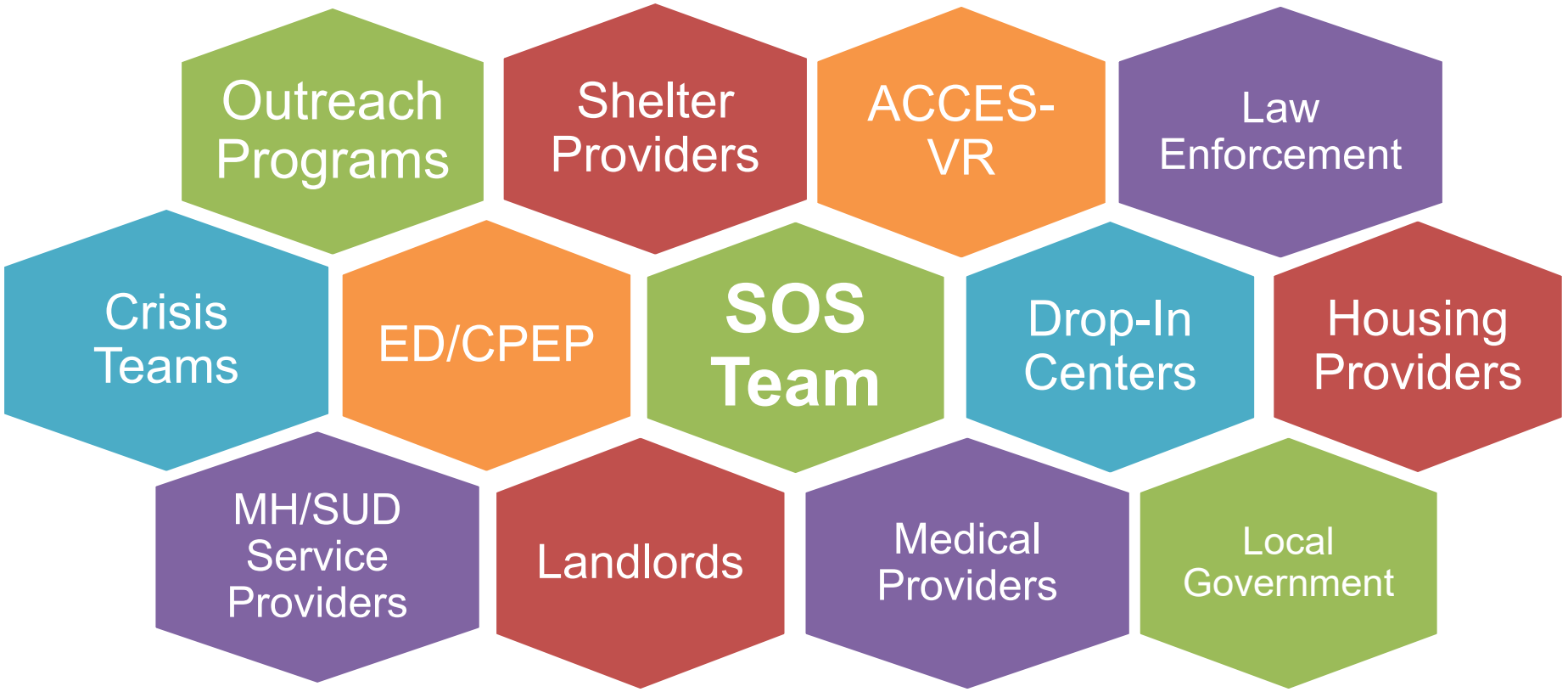
SOS Care Coordination

- Resolve Immediate Needs
  - Food, clothing, and referrals to community supports like pantries, soup kitchens, and emergency assistance
- Expanding the Circle of Care
  - Linkages to healthcare provider, behavioral health and substance use services
- Housing
  - Complete or coordinate housing referrals and applications
- IDs and Entitlements
  - Assisting in applying and ensuring members have appropriate paperwork to receive aftercare services
- Continuity of Care
  - Coordination with inpatient and outpatient providers
- Community Integration
  - Expanding social support networks, connecting to vocational/educational opportunities, and other hobbies or interests

Safe Options Support (SOS) Teams

- What we aren't and what we can't do
  - The SOS Teams are not crisis intervention teams
  - Work with individuals who are currently enrolled with another high-intensity level of care (e.g. ACT, IMT); this would typically not be considered for enrollment in an SOS Team.
  - The teams in their makeups are not equipped to provided the higher level of care for needed for the following populations:
    - Intellectual or Developmental Disabilities, Dementia or other conditions leading to severe and persistent cognitive limitations
    - Other major neurocognitive disorder diagnosis

Provider Collaboration



Interagency Collaboration

Office of Temporary and Disability Assistance

NYS Office of Mental Health

Local Dept of Mental Hygiene

Continuum of Care

SOS Provider

Local Dept of Social Services

SOS Data & Outcomes

SOS Data & Outcomes

In NYC, from April 2022 – Sept. 2025:

- Over 75,000 outreach encounters
- Nearly 2,700 individuals placed in Safe Haven / shelter
- Approximately 5,900 referrals received
- 2,915 individuals enrolled into SOS services.
- 838 individuals have obtained stable housing

Outside NYC, from Fall 2023 – Sept. 2025:

- Over 29,300 outreach encounters
- Nearly 460 individuals placed into temporary shelter
- Over 4,800 referrals received
- 899 individuals enrolled into SOS services.
- 578 individuals have obtained stable housing

Low Barrier Supportive Housing

Eligibility & Enrollment

- 300 Scattered Site Supportive Housing Units awarded in NYC and 225 units awarded in rest of state for street homeless individuals referred from SOS or ACT.
- Expedited referral, low barrier admission process. Providers lease units in advance to facilitate rapid placement.
- 1:15 staff to consumer ratio; housing staff visit consumer 4 times per month via face-to-face contacts and home visits - may decrease over time.
- Residents of supportive housing pay 30% of their income towards rent and reasonable utilities.

Housing Data & Outcomes

- Between Oct. 2023 – May 2025, approx. 270 people have been admitted into low barrier supportive housing units.
- Of those SOS members admitted, 260 remain stably housed.
- Of the 225 units awarded to rest of state, over 80 people have been admitted.

Monroe SOS CTI Team

Liberty Resources, Inc. – Monroe County SOS Team

INFORMATION & INSIGHTS

- We use an intercept model for outreach: embedding ourselves and collaborating with existing outreach teams and points of contact: *hospitals, shelters, churches, crisis teams (FIT and PIC), other outreach teams, community centers*
- Barrier free referral for outreach via phone or encrypted email (*to date over 600 referrals)*
- SOS Team screens for eligibility which allows for minimal case management in the outreach phase, even for folks we do not enroll
- Enrollment is a commitment based on the individual's fit for the program based on needs, barriers, history, and desire (*to date 72 enrollees)*
- Team collaboratively determines best assignment based on client case presentation and case load
- Regular group processing of complex needs and barriers via weekly outreach and case conference meetings

Liberty Resources, Inc. – Monroe County SOS Team

SUCCESSES

- Collaboration with the county including: *referral hub for processing enrollments, partnership with DHS, participating in collaborative community meetings/discussions (*outreach teams, Dept. of Transportation, Rochester PD, CoC, complex case reviews, etc.*) unique workflows for hospital referrals*
- Team cohesion and workforce culture
- Flexibility to provide holistic, wrap around support
- Most discharges have been a result of graduation
- Housing access (*65 persons housed to date)*

CHALLENGES

- Discharging individuals after 9 or 12 months who have significant needs
- The volume of referrals and gaps in available resources for non-eligible clients
- Navigating multiple systems, as well as collaborating with multiple external providers and multiple team members

LIBERTY RESOURCES

Safe Options Support

Community Outreach Team

In partnership with
En Colaboración Con

SERVICES OFFERED

- Ongoing Supportive Care & Skills Building
- Behavioral Health Counseling
- Housing Support
- Immediate Needs Support (Food / Clothing) Resources
- Linkage to Medication-Assisted Treatment for Substance Use
- Entitlement Support

SERVICIOS OFRECIDOS

- Cuidado de Apoyo Continuo y Desarrollo de Destrezas
- Consejería de Salud Mental
- Ayuda con Obtener Vivienda
- Recursos de Apoyo para Necesidades Inmediatas (Alimentos/Ropa)
- Vínculo con el Tratamiento Asistido por Medicamentos para el Uso de Sustancias
- Soporte de Derechos

FOR INFORMATION & SUPPORT

1-855-SOS-4ROC
After Hours Support Available
Soporte fuera de horario disponible

175 N Winton Rd
Rochester, NY

www.liberty-resources.org

SOSTeam@liberty-resources.org

PARA INFORMACIÓN Y APOYO

BH-102 (10/11/23

WELCOME to SOS!

LIBERTY RESOURCES

SOS IS A CRITICAL TIME INTERVENTION PROGRAM: WE WILL WORK WITH YOU TO NAVIGATE ACCESSING HOUSING & WORK WITH YOU FOR 9 MONTHS AFTER HOUSING.

Our Role

- honor your needs as best we can
- support you while you navigate your own care
- connect you to resources & providers
- provide temporary support
- offer a Story Circle group each month
- support your growth

Your Role

- be open and willing to connect weekly
- be the expert in what you want--identify goals for growth
- engage in mutual respect
- honor boundaries
- have a willingness to explore options

F.Y.I

- we can refer you to crisis lines but cannot provide crisis care
- our appointments need to be scheduled in advance
- we navigate housing but can't always find what you need when you need it
- We can connect you to transportation resources but can not be your primary source of transportation
- we only work in Monroe county
- we are mandated reporters

GENERAL SOS LINE: 1-855-767-4762
SUICIDE AND CRISIS LIFELINE: 988
LIFELINE FOR BASIC NEEDS: 211

Supportive Housing First- Rochester Program

Helio Health®
Where hope meets healing

- Assists individuals living in Monroe County by increasing housing stability and wellness

  - 20 one-bedroom apartments and 5 studio apartments.

  - Lease will be in the resident's name.

Helio Health®
Where hope meets healing

- Residents pay 30% of their income towards rent and reasonable utilities. Helio Health pays the difference as well as the security deposit.

- Case Managers will meet with residents weekly and additionally as needed.

Helio Health®
Where hope meets healing

- Residents will receive ongoing support from Helio Health Case Managers and community providers.

For more information, please contact Beth Clark at BClark@helio.health

Helio Health®
Where hope meets healing

Role of DSS

Role of the Peer Specialist

Role of the Peer Specialist

- Peer Role
  - *Within team structure*

- Benefits of the peer role
  - *Lived experience*
  - *Rapport building*

- Success Stories
  - *Outreach*
  - *Enrolled*

- Challenges
  - *Ethical*
  - *Role Clarity*
  - *Systematic Barriers*

Questions?

Office of Mental Health