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

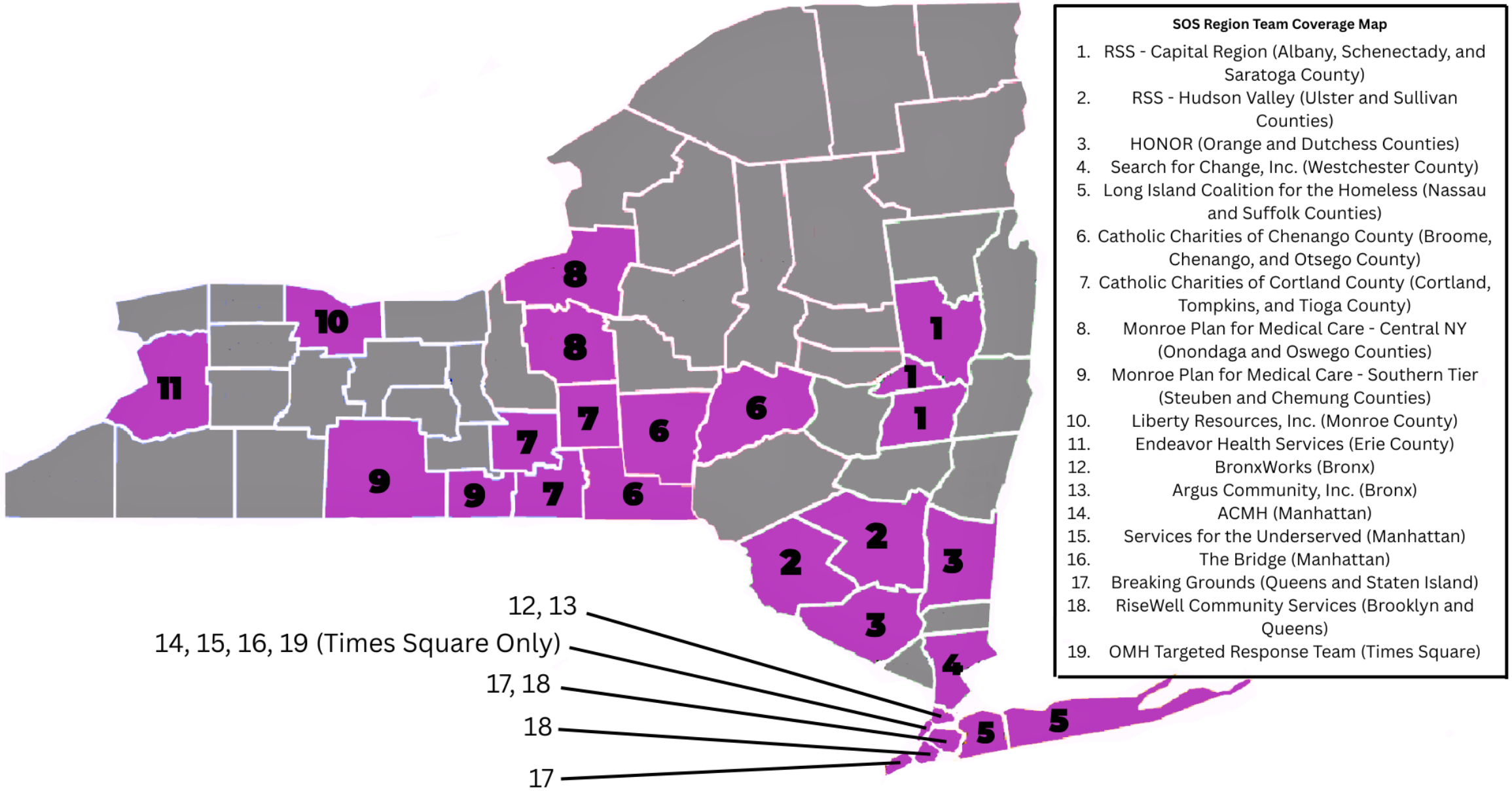
- Multidisciplinary teams using Critical Time Intervention approach to provide intensive outreach, engagement, and care coordination services to unhoused individuals until stably housing (approx. 9-12 months).

- 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)

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

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.

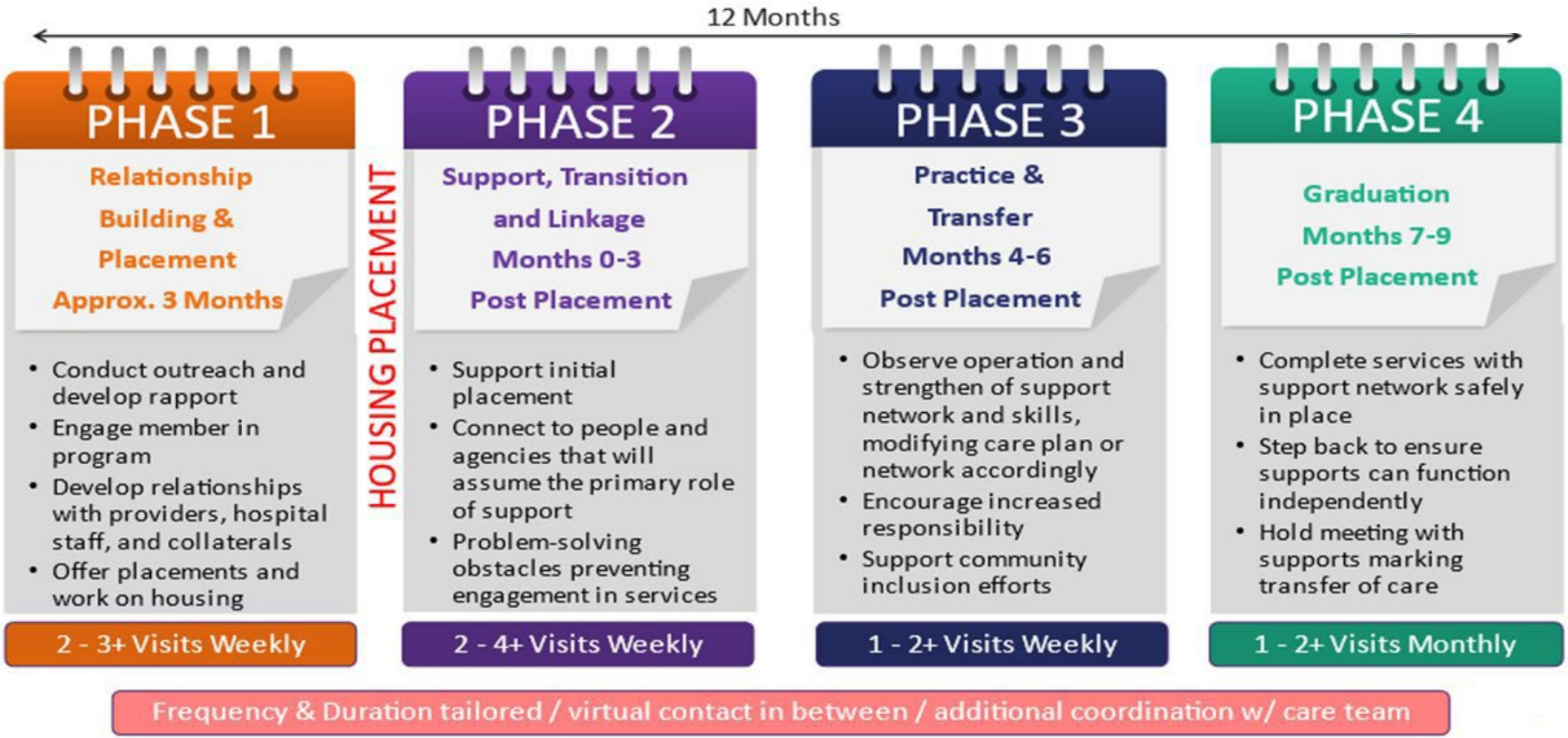
- SOS referrals can be made by hospitals, community stakeholders, agencies, family, other supports. Upon receiving a referral, SOS Teams respond within 24-48 hours to initiate outreach efforts.

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

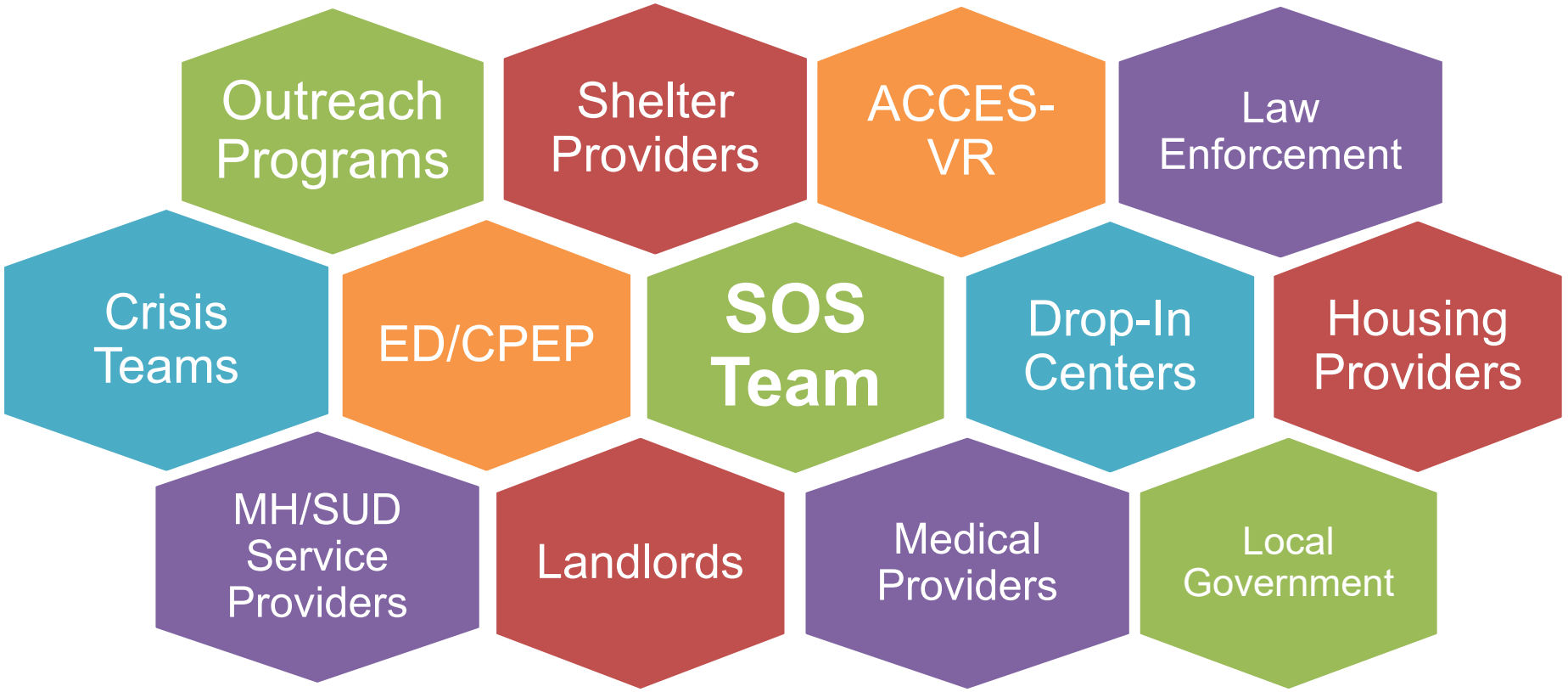
Direct Services

- 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

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

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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.

Ulster/Sullivan SOS CTI Team

Challenges Faced by Rural SOS Teams

- No shelters
  - County social services contract with motels for shelter placement
    - Once motel rooms run out there is no more places to stay *(1)*
  - During winter months warming stations are open (12/1-4/1)
    - 1 county warming station operates 24/7
    - 1 county has 2 small centers in the basement of churches
      - 7 days/ week 8pm – 8am
- Most services in the county are concentrated into one or two urban centers
  - For most people in the county these services are at least a 30-45 minute car ride or a 1-2 hour bus ride.
- Transportation
  - Buses do not operate on a 24-hour schedule and do not run on holidays

Challenges Faced by Rural SOS Teams

- Airbnbs, second homes, and tourism
  - During the pandemic people fled NYC to the Hudson Valley
  - Lowest current rents for 1 br apts is about $1400
    - Income may need to be 2.5xs your rent
    - Bad credit and legal hx will disqualify you
  - Motel owners are more likely to try to attract tourists rather than DSS
  - Many motels have told us they will no longer rent to the type of people we help
- Visibility
  - Working in an area that is heavily wooded
    - It can be a challenge to find where people are camped out
    - Safety concerns regarding being in isolated locations
- Lack of cell service
  - Both counties have large areas where teams and homeless have no cellphone service

How Have We Adjusted?

- Uber accounts
  - Access to services is limited due to limited transportation options
  - Uber accounts free team members up for other tasks and are available after hours*(2)*
- Utilizing local police departments and mobile response teams
  - We use them for information and sometimes to pass information and supplies to people we are trying to engage
- Maintain vehicles
  - Personal and company

How Have We Adjusted?

- Teams carry tents in their vehicles
  - For many there is no other option but to sleep outside
- The woods
  - We have provided tents, boots, sleeping bags
    - Purchase three season or cold weather tents
  - Propane tanks for heat and cooking
- Networks (are not large and people talk)
  - Work closely with local government
    - County social services, departments of mental health, mobile mental health teams…*(3)*
  - Less anonymity, relationships become very important
  - Having the right people in your contacts
  - Be the person other people want to collaborate with
  - The reputation of the team will help spread the word among people who need your help

How Have We Adjusted?

- Driving
  - We purchased AWD small SUV type vehicles
    - Roads are not always maintained
    - Weather conditions can change rapidly
  - Provide cellphone holders in phones
  - Learn to safely use technology to talk/voice text while driving
  - Travel time becomes an opportunity to decompress or get some calls and messages done. Take advantage of this time.
  - There will be a lot of driving and alone time
    - Team text thread, check ins, locations, and helping each other

How Have We Adjusted?

- Try to be proactive
  - If county is experiencing extreme heat or cold, we increase our outreach to provide as many supplies to as many people as we can
- Advocate
  - Talk to anyone and everyone about what the teams see on the ground
  - Participate in work groups, advisory committees, county meetings
    - Continuum of Care meetings
    - County Street Outreach meetings, PIT counts …
    - *Never stop talking about how much people are struggling!*

Role of DSS

The Role of DSS

- Effective delivery of social services in a rural environment demands that a DSS meets people where they are.
- Impacts of disabilities and lack of transportation are more profound
- Health outcomes held back by lack of access to primary care
- Administrative systems are outdated – overly reliant on phone and snail mail – frequent source of frustrations and self-withdrawal from services

- Crisis Mental Health and SOS-CTI teams perform outreach that a DSS is not equipped to provide on its own.
- Flexibility is tremendously important and beneficial
- Street outreach affords opportunities to interconnect human services that can't be done from behind a desk
- Provides valuable feedback on conditions in the community, at hotels, etc.

- DSS and SOS-CTI partnership is making the community safer and healthier
- Housing First model is critical enabler in combatting chronic homelessness
- SOS "Purple Shirts" are a calming presence for DSS staff and clients alike
- Local elected officials and PDs are grateful for the assistance in providing a compassionate, non-punitive method to get homeless off of local streets and out of unsafe structures

Westchester SOS CTI Team

Key Barriers in Westchester County

Lack of vacancies in the shelters

Though Westchester have approximately 5 drop in shelters, it is quite often that they reach capacity and turn individuals away.

Shelter bans

We have encountered clients that are banned from shelters. Clients are often told that they are banned indefinitely from shelters.

Shelter Cost

Some clients who are on fixed income SSI, SSD or SSDI are reluctant to pay for shelter

Key Barriers in Westchester County Cont.

Affordable Housing

- There is a lack of affordable housing for Rapid Rehousing and Permanent Supportive Housing.
- Housing providers struggle with securing suitable apartments
- Landlords reluctant to work with unsheltered individuals

Housing for the aging population

- Memory loss, what about consent?

We have on occasions paid for hotels stays for clients.

Advocacy

We meet client where they are.

Facing the Barriers

Facing the Barriers cont.

We took on the role of being housing specialist.

Building relationships with landlords and brokers

What is working?

Being Client Centered	Allowing clients to be the expert of their lives
Housing Specialist Role	Of the 35 clients housed, 11 were because of the team's diligence
Housing First	Housed individuals living in the woods
SOS	Housed individual that was unhoused for 11 years

Sullivan/Ulster Housing First

HONOR Housing First Program

- Targets street homeless individuals referred from SOS and ACT.
- Housing Agency rents apartments, furnishes them and turns on utilities – “Master Leasing”
- Housing Agency maintains low barrier admission policies that promote a rapid transition from homelessness to housing.
- An expedited referral process: Once consumer has seen and accepted an apartment, the consumer will move in on the same day as viewing the apartment or as quickly as possible.
- The Housing Agency and the SOS Teams need to work together to ensure that there is an adequate supply of food and personal care items in the apartment for the tenants.
- Housing Agency, SOS team will meet with consumer to assess needs, link consumer to services and develop a support plan.
- Supportive housing staff will be expected to meet with newly admitted tenants at least four (4) times per month, through face-to-face meetings and home visits.
- The SOS teams will remain involved with the individual for up to a year

Role of the Peer Specialist