

Coordinating Systems of Care to Provide a Comprehensive Behavioral Health Crisis Response to Homeless Individuals

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INTRODUCTION: Housing is widely understood to be a key factor in health outcomes in the United States, yet behavioral health crisis response systems and homelessness systems operate separately, impeding holistic approaches to stabilization. Stronger coordination between these systems can enhance the power of available resources, mitigate crises, and promote recovery for individuals who are homeless with behavioral health needs. This brief suggests strategies to enhance crisis care through multilevel coordination and describes practical approaches that systems of care can deploy to strengthen collaboration.

The Potential Cycle of Crisis

The psychological and physical stressors of homelessness can precipitate and exacerbate the symptoms of serious mental illness and substance use disorders (SUDs), potentially contributing to the escalation of symptoms into a crisis. In many communities, particularly in rural regions that lack adequate resources,

➔ **Behavioral health crisis:** An emergency created by severe emotional distress, a mental disorder, or substance use.

behavioral health crisis response relies on law enforcement and, in turn, the hospital system. This situation can result in unnecessary trauma, arrest, incarceration, hospitalization, and sometimes even death.¹ As a direct result of such interactions, additional barriers to stabilization may occur, such as criminal records or loss of income, contributing to a potential cycle of crisis (see Figure 1).

These detrimental and preventable outcomes disproportionately impact some communities, including people with disabilities and those living in rural areas.² Further, people may experience barriers that can perpetuate behavioral health crises, including a lack of access to behavioral health care, safe and affordable housing, and other basic needs.^{3,4}

Fortunately, an effective and comprehensive system geared toward addressing other resources that support stability offers many ways to improve outcomes and interrupt the cycle.

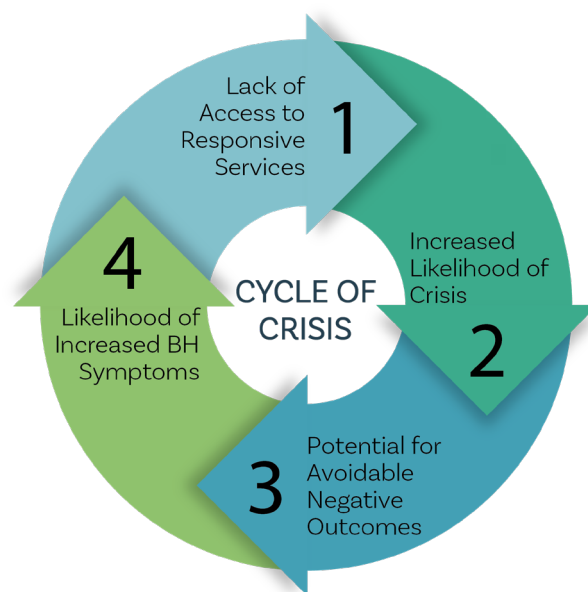


Figure 1: Cycle of Crisis

Effective Crisis Response and the Promise of 988

The Substance Abuse and Mental Health Services Administration (SAMHSA) established [national best practices](#) [PDF] and defined the components of an effective crisis continuum: clinically staffed 24/7 call centers, 24/7 mobile crisis teams, and crisis stabilization units that provide short-term (for up to 24 hours) stabilization services in a community setting. While many calls can be resolved over the phone, the 988 Suicide and Crisis Lifeline also provides individuals with a gateway into the array of interconnected crisis services built within a community.

A robust, community-based service continuum can reduce reliance on law enforcement, and create a

- ➔ **Crisis stabilization unit (CSU):** Offers an alternative to emergency department and psychiatric hospitalization admission by providing short-term observation (for up to 24 hours) and stabilization services in the community.
- ➔ **Mobile crisis:** Teams consisting of a behavioral health specialist and another professional, often a certified peer; the team conducts psychiatric assessments, de-escalates crises, and collaborates to connect individuals to appropriate treatment. Mobile crisis connects with individuals wherever they are, including home, work, or other community-based settings, to provide rapid support services.

centralized entry point into behavioral health services. Although continued cross-system planning and ongoing investment are necessary to effect long-term change, homeless, housing, and behavioral health crisis providers can take steps now to ensure a more appropriate response to individuals who are homeless. These providers can use a range of techniques to disrupt the cycle of crisis and support individuals who are homeless before, during, and after a behavioral health crisis.⁵

WHAT IS 988?

The [988 Suicide and Crisis Lifeline](#) offers 24/7 call, text, and chat access to trained counselors who can support individuals experiencing suicidal, substance use, or mental health crises. Now consisting of over 200 call centers across the country, 988 was built upon the existing National Suicide Prevention Lifeline infrastructure. Calls are routed by area code, and a centralized process ensures that each call is routed to a national backup line if a local call center is unable to answer.

The launch of 988 is an important step in reimagining behavioral health crisis care. Ultimately, 988 should provide not only an immediate response but also centralized access to a robust *continuum* of services (including mobile crisis, crisis stabilization, respite, and peer respite) supported by state and local investment. Currently, 988 implementation is different in every state; many are still actively working to expand funding capacity and integrate 988 into their broader crisis system. In other states, Utah and Georgia for example, 988 call centers are fully integrated into the crisis continuum and 988 clinicians can directly dispatch mobile crisis teams.

See [which states have passed legislation to support 988](#) and find out [more about 988](#).

➔ **Peer respite:** Short-term, voluntary, community-based support in a residential, homelike setting where the primary support is provided by individuals with lived expertise and training in peer support.

Action Steps for Effective Crisis Response

Crisis Prevention and Early Mitigation

An individual who is homeless may engage with multiple providers prior to accessing the crisis system. Each of these providers can play an active role in disrupting the potential cycle of crisis. For example, providers can support individuals in creating crisis plans that identify each person's preferences and action steps should they experience a behavioral health emergency. [Wellness Recovery Action Plan \(WRAP\)](#) is one process for identifying the person's preferences and creating a plan, and it can also enhance people's

awareness of both formal and natural supports and resources. These plans should be started at intake and continuously updated as needs change. Knowing a person's preferences and self-identified signs of crisis can help providers respond appropriately to de-escalate and stabilize a stressful situation. Providers can and should develop protocols to support frequent and targeted engagement strategies, including using peer support services, to prevent escalation. When responding to crises, personnel should inquire about the existence of crisis plans and consider these plans in their response.

Additionally, call centers that are integrated into their region's broader health and housing systems can use warm handoffs to more effectively assist individuals in connecting or reconnecting to behavioral health services and housing supports, preventing the escalation of a mental health crisis. Examples of actions that promote crisis prevention and mitigation and examples of communities that have used these strategies are in the table below.

➔ **Warm handoff:** The process of transferring an individual from one provider to another in person and with the referring participant present, utilizing a foundation of trust and respect.

Crisis Prevention and Mitigation

Homeless and Housing Providers	Behavioral Health Crisis Providers
• Create individualized crisis plans with housing and homeless service program participants that identify preferences and actions to be taken should a crisis arise. ○ Utilize the WRAP process to create awareness of support and resources to mitigate crises. • Embed peer support staff into outreach, shelters, and housing programs to provide additional support to individuals and help avert potential crises. • Coordinate proactively with behavioral health providers to support greater access to behavioral health care for individuals who are homeless.	• Create a formal, bidirectional referral system with homeless and housing service providers to facilitate warm handoffs. • Engage in cross-sector learning collaboratives, case conferences (as appropriate), and training with housing and homeless service providers. • Maintain a working knowledge of available resources to help meet basic needs (e.g., eviction prevention, food assistance), and offer support in connecting to resources. • Assist individuals in connecting to services that are part of the broader health continuum to prevent future crises.

Crisis Prevention and Mitigation

Community Examples

- [Kennebec Behavioral Health](#) in Maine provides both adult and youth homeless outreach services, and a team coordinates with youth to create crisis plans to promote autonomy and identify choices during crises.
- SAMHSA's [Project for Assistance in Transition from Homelessness \(PATH\)](#) supports an array of activities, including outreach, community mental health, and supportive services. Many states have used these programs to support connections to behavioral health services and prevent crises.
- [The Community Response Team](#) in Washington, DC, regularly engages with homeless outreach providers to accept referrals for its behavioral health outreach, which connects individuals to services and deflects the need for crisis response. This practice also allows for better ongoing coordination with homeless service providers.

Enhancing Crisis Response

Real-time coordination among providers can ensure that individuals are connected to support quickly and effectively. All providers should ensure their staff is trained and skilled in de-escalation techniques. Appropriate training ensures that staff can confidently support individuals in crisis. Training should teach participants to respond calmly and proactively to both mental health and substance use situations, including when and how to use naloxone (sold under the brand name Narcan) and how to access available resources. For example, peer-run warmlines may be a good option for individuals who feel more comfortable contacting someone with comparable lived expertise.

Providers should regularly conduct [self-assessments](#) [PDF] and obtain feedback to ensure that the services offered are trauma-informed and enhance self-determination. Trauma-informed approaches should foster the psychological safety of the person, transparency in processes, and collaboration, and they should ensure personal autonomy and empowerment throughout the engagement. An example of a trauma-informed measure is the establishment of appropriate procedures for safely securing the personal property and pets of unsheltered individuals who need community stabilization services. Additional examples of community approaches to enhance crisis response are provided in the table below.

➔ **Warmline:** A peer-run hotline that offers callers emotional support and resources and is staffed by individuals who have lived experience of recovery.

Community Approaches to Enhance Crisis Response

Homeless and Housing Providers

- Ensure staff have ongoing training and proficiency in recognizing and responding to behavioral health crises, including de-escalation, and mental health first aid.
- Conduct training on available crisis continuum services, including peer warmlines, peer-run respite, and crisis respite programming.
- Utilize trauma-informed approaches during engagement.
- Collaborate with crisis providers to locate and coordinate with individuals who are unsheltered.
- Co-locate, when possible, with behavioral health services to facilitate an effective response.
- Recruit workers who reflect the communities being served and take steps to bridge gaps that can deter engagement.
- Solicit feedback from individuals with lived expertise and people using services to evaluate and improve interventions.

Behavioral Health Crisis Providers

- Utilize catchment systems and strategic deployment to provide an appropriate response to individuals who are homeless who may need crisis response services.
 - Create staff positions/teams with advanced training in homeless services systems, the SUD system of care, and homeless outreach.
- Create trauma-informed policies and procedures that specifically relate to individuals who are homeless.
- Train staff in SUD assessments and facilitate access to medication-assisted treatment (MAT).
- Equip staff with overdose prevention and response supplies such as naloxone, and ensure all personnel are trained to use them.
- Recruit workers who reflect the communities being served and take steps to bridge gaps that can deter engagement.
- Consider strategies to improve law enforcement response to behavioral health crises, including co-location, co-response, diversion, and warm handoffs.
- Collaborate with medical providers and emergency medical personnel on assessment and response for unsheltered individuals with co-occurring behavioral health and medical conditions.
- Solicit feedback from individuals with lived expertise and people using services to evaluate and improve interventions.

Community Approaches to Enhance Crisis Response

Community Examples

- OUR Place in Reno, Nevada, employs clinicians in its shelter facility and engages in cross-training to ensure shelter staff can quickly respond to any crisis. Staff collaborated with the Mobile Outreach Safety Team and saw a 95 percent reduction in calls to 911 from the shelter for concerns related to behavioral health.⁶
- Los Angeles, California, opened Safe Landing, a “no wrong door” interim housing site that integrates housing and health services by including a medical clinic, 36 triage beds for behavioral health stabilization, interim housing for individuals and pets, and connection to housing systems.
- In Illinois, PATH is a 988 crisis call center, a Central Illinois Continuum of Care (CoC) lead, and a homeless service provider. This co-location lays the groundwork for effective collaboration and crisis response to individuals who are homeless.
- In Houma, Louisiana, START Corp is a Federally Qualified Health Center that has long provided homeless services and recently expanded to mobile crisis and walk-in crisis services. START Corp engages in cross-training and has housing specialists on its mobile crisis teams.⁷
- Albuquerque Community Safety is composed of social workers, behavioral health clinicians, homeless and housing specialists, and violence prevention specialists. Appropriate staff respond based on the nature of the call and the needs of individuals.
- Washington expanded access to services through the Native and Strong Lifeline, a subcomponent of 988 providing access to Native crisis counselors who offer crisis intervention, emphasizing traditional healing practices.
- In California, Riverside University Health System’s Mobile Crisis Teams [PDF] consist of clinical specialists, therapists, SUD specialists, homeless and housing specialists, and peer support specialists.
- The Boston Emergency Services Team carries naloxone while responding to crisis calls.
- San Francisco’s Street Crisis Response Team consists of a clinician, a paramedic, and a peer support specialist who respond to behavioral health emergencies in public spaces. The team predominantly serves individuals who are homeless and conducts follow-ups to connect individuals to housing and support.

- ➔ **Co-response:** Although there is great variability in how communities have operationalized the practice of co-response, this is a universal term in which a behavioral health clinician responds with a law enforcement officer to a behavioral health crisis call.
- ➔ **Crisis respite program:** A homelike place that offers an alternative to hospitalization for individuals having emotional and behavioral health crises.
- ➔ **Diversion programs:** An encompassing term that refers to programming that attempts to move individuals away from unnecessary encounters with the criminal legal system by providing an alternative response, often rooted in community health solutions.

Ensuring Continuity Post-crisis

After an in-person crisis response, providing follow-up care ensures ongoing connection to services and promotes recovery.⁸ Crisis providers should ask each individual if they would like to receive further services, explain the services offered, and follow up during an agreed-upon timeframe. Warm handoffs to ongoing support can interrupt the cycle of crisis and prevent recurrences. Some crisis providers offer the services of peer support specialists who can accompany individuals after their crisis, helping them schedule and get to follow-up appointments. All post-crisis support should include coordination to ensure connection to appropriate housing support services. Homeless and housing providers who have a working relationship with the individual can also offer post-crisis supports, such as providing space to debrief if the individual wishes and prompting re-engagement in services to support any outstanding needs. Examples of post-crisis strategies for providers, and communities that have taken steps to ensure post-crisis support, are in the table below.

Post-crisis Strategies

Homeless and Housing Providers	Behavioral Health Crisis Providers
• Create post-crisis re-engagement protocols that ensure the capacity to accept warm handoffs from crisis providers and quick re-engagement with housing and service providers. • When possible, facilitate access to temporary housing as needed for those coming out of a crisis.	• Engage in follow-up services to ensure warm handoffs to community providers, including supportive housing and homeless street outreach. • Integrate crisis services into the broader behavioral health system to streamline follow-up by community providers.
Community Examples	
• Seattle’s (Washington) Downtown Emergency Services Center (DESC) offers integrated behavioral health and housing services, co-locating its clinical services in shelters. DESC also runs a crisis respite facility that serves individuals who are homeless and provides stabilization post-crisis. In addition, it serves as an access point for the Housing and Urban Development (HUD) coordinated entry system. • Washington’s PATH outreach teams coordinate with crisis providers to ensure rapid post-crisis follow-up; peer “pathfinders” [PDF] provide support and SUD outreach to individuals in hospital emergency departments and in encampments.⁹	• Mobile Crisis Response Team out of San Diego, California, can conduct follow-ups for 30 days and coordinates with homeless outreach and housing providers. • Kiva Centers, a peer-led agency in Massachusetts, provides peer bridging, or supportive services, to individuals transitioning from psychiatric facilities or crisis stabilization units. • Connections Health Solutions in Tucson, Arizona, incorporates transitional care coordination services into the acute crisis stabilization unit to connect individuals with behavioral health services and support and prevent a reemerging crisis.

Enhancing Community Partnerships

Housing and behavioral health crisis providers can enhance community partnerships to ensure that individuals who are homeless are connected to the right services before a crisis emerges. For unsheltered individuals, community partners can include libraries, community recreation centers, coffee shops, churches, and other entities that may provide protection from the environment. Often, partners call 911 for assistance when they perceive a behavioral health crisis; however, crisis providers should engage in community education to expand awareness of existing services and 988 and prevent inappropriate calls to 911. Crisis providers can also educate partners on signs of impending crisis and provide their staff with tools for de-escalation.

While providers should take steps to minimize unnecessary contact with law enforcement for individuals in crisis by creating alternative avenues for support, the crisis infrastructure is not yet sufficient in many communities to support this approach, and law enforcement and emergency medical technicians (EMTs) continue to be the default responders for behavioral health crises. In these communities, providers should partner directly with law enforcement officers to offer training on appropriate and available services, and methods to mitigate crisis escalation.

The table below shows strategies to enhance cross-sector partnerships and examples of communities that have built on these approaches.

Strategies to Enhance Cross-Sector Partnerships

Homeless and Housing Providers	Behavioral Health Crisis Providers
- Enhance informal community partnerships with establishments frequented by individuals who are homeless; encourage them to contact outreach and homeless service providers rather than law enforcement when a behavioral health situation occurs. - Strengthen partnerships with local crisis providers to support real-time coordination and warm handoffs. - Mitigate law enforcement contact by improving awareness of services and creating opportunities for partnership. Specific strategies can include the following: - Coordinate with Crisis Intervention Training (CIT) programs and crisis providers to ensure the training offers instructions specific to engaging individuals who are homeless. - Attend roll call meetings with law enforcement partners to build strong relationships and inform them of services and referral processes.	- Participate in local CoCs, encourage resource-sharing, and consider becoming a housing service provider. - Facilitate training for homeless and housing providers, law enforcement, and other community partners on mental health first aid, signs of a behavioral health crisis, and effective de-escalation techniques. - Participate in cross-sector learning collaboratives, case conferencing (as appropriate), and training with housing and homeless service providers. - Educate the public, first responders, libraries, churches, and other formal and natural support systems to expand awareness of and access to services. - Mitigate law enforcement-led response to behavioral health crises through co-location, co-response, diversion, and warm handoffs.

Strategies to Enhance Cross-Sector Partnerships

Community Examples

- In Washington, DC, [Pathways to Housing's](#) street outreach teams collaborate with local law enforcement and national park police by regularly attending roll call and cross-provider meetings.¹⁰
- Since 2020, Starbucks has been working with trained outreach workers in eight cities to respond more effectively to individuals who are homeless who have behavioral health conditions.¹¹
- The [Policing Alternatives and Diversion Initiative](#) in Atlanta, Georgia, has two components to redirect individuals to appropriate services: [311 community referrals](#) [PDF], which allow community members to directly refer individuals, and [pre-arrest diversion](#), which allows law enforcement to divert arrests when there is a substance use, mental health, or poverty need.
- [California State Library's Mental Health Initiative](#) prepares librarians to serve individuals with behavioral health conditions and includes a training module on outreach.
- [Native American Connections](#), in Maricopa County, Arizona, began providing holistic and traditional healing as part of its behavioral healthcare continuum and expanded to include housing and housing supports.
- Cross-system collaboration between hospitals, behavioral health providers, and law enforcement in Malheur County, Oregon, led to innovative solutions using limited resources, including coordination to support transportation to a homeless shelter in a nearby community.¹²

Opportunities for HUD Continuums of Care and Behavioral Health Systems

While behavioral health and homeless service providers can coordinate to provide more effective direct support to individuals in crisis, there are also systemic actions that states and communities can take to enhance services and promote collaboration. State behavioral health authorities (SBHAs) are responsible for administering behavioral health support services funded through SAMHSA's Mental Health Block Grant or state funding. They often work in tandem with state Medicaid agencies to ensure service provision and funding for behavioral health crisis services. SBHAs can utilize crisis provider contracting and regulatory standards to ensure more intuitive responsive services, enhance provider training, and promote collaboration with homeless and housing systems.

HUD CoCs are local planning entities that coordinate federally funded housing and services for homeless

individuals and families. CoCs promote community coordination and engage in strategic planning to improve access to available housing resources and supportive services, including behavioral health. CoCs should bring behavioral health crisis providers into planning and implementation efforts. They can encourage providers to engage in best practices, provide technical assistance, and create cross-provider learning opportunities. Many states have the infrastructure to support more effective cross-sector planning through [Interagency Councils on Homelessness](#) or 988 crisis planning task forces, but states need to ensure that all the key players are at the decision-making table. The table below shows how CoCs and SBHAs can support coordination efforts and community examples of successful alignment.

How CoCs and SBHAs Can Support Coordination Efforts

HUD Continuums of Care	State Behavioral Health Authorities
• Create seats for behavioral health crisis service providers on the CoC governing body. • Coordinate with crisis providers to create coordinated entry access points at crisis services (through telephonic intake, co-location of services, or direct provision of housing assessments). • Ensure CoC providers cross-train with crisis providers and are aware of local alternative resources (e.g., mobile crisis, peer respite). • Coordinate with local 988 providers to ensure knowledge of CoC resources and eligibility. • Collaborate with the SBHA or crisis provider network to create data-sharing agreements. • Encourage best practices for crisis coordination among providers throughout the CoC: ○ Ensure homeless service providers work with individuals to identify preferences should a crisis occur. ○ At intake/reassessment, request releases of information that support coordinated crisis response. • Provide training, technical support, and learning collaboratives to the homeless provider network on crisis response and crisis prevention planning. • Ensure and prioritize access to housing for individuals with frequent crisis system contact who would benefit from robust housing supports.	• Utilize contracting and regulatory standards to ensure crisis providers engage in the following: ○ Cross-system coordination and crisis task force planning ○ Coordination and cross-training with local CoCs ○ Dispatching mobile crisis teams by need and skillset or using a specialty team for homeless individuals ○ Trauma-informed services • Encourage behavioral health providers to actively participate in the CoC. • Conduct system needs assessments, identify gaps in care, and invest in addressing identified gaps. • Coordinate with Medicaid to ensure appropriately compensated peer support staff are employed across the crisis continuum. • Improve data collection and reporting on housing status among crisis providers, and use the data to identify and close gaps in access to services. • Use data to measure the prevalence of homelessness among service utilizers. • Remove barriers to crisis response by implementing a “no wrong door” approach. • Expand access to upstream behavioral health care.

How CoCs and SBHAs Can Support Coordination Efforts

Community Examples

- [Sacramento's CoC Board](#) has representation from [Wellspace](#), the region's 988 operator, and the county's behavioral health authority. This allows 988 to ensure CoC resources are suggested to callers who are homeless.
- Connecticut's CoCs merged their homeless management information systems software into one [platform](#). This allowed for a single release of information to permit sharing data with Medicaid, enabling them to prioritize individuals with frequent service utilization, including crisis and hospitalization services.
- [New York's Crisis Stabilization Center \(CSC\) regulations](#) [PDF] require CSC providers to partner with the Department of Social Services on housing coordination. CSC discharge instructions must be made available to providers, including housing providers, as authorized by the individual.
- Alleghany County's (Pennsylvania) [integrated data system](#) [PDF] allows it to create cross-system comparisons, evaluate crisis response data to identify trends, and engage in strategic planning.
- Minnesota mobile crisis teams are required by [statute](#) to assess if the individual has a [psychiatric advance directive](#) [PDF] and, as appropriate, attempt to abide by the terms.
- California released a [request for proposals](#) [PDF] to provide behavioral health crisis services and non-crisis services, including traditional healing practices.
- In the wake of the COVID-19 pandemic, states are exploring avenues to enhance telehealth access to underserved and remote areas.
- Idaho increased behavioral health access in remote areas through [telehealth services in libraries](#), expanding access to care for homeless individuals.

➔ **Upstream services:** Interventions and services that address underlying factors affecting health, such as income and housing stability, in order to promote positive outcomes and prevent future crises. These services can focus on improving factors such as income, housing stability, and access to other basic needs by providing an alternative response, often rooted in community health solutions.

Conclusion

Providing comprehensive crisis services for individuals who are homeless requires a multipronged approach that enhances care at the provider level, leverages resources at the community level, and coordinates systems at the state level. Such initiatives should include appropriate representation from the state behavioral health authority; the state agency on substance use prevention, treatment, and recovery; the state Medicaid agency; state and local housing agencies; corrections departments; behavioral health providers; and individuals with lived expertise. A behavioral health crisis advisory board, consisting of multiple individuals with lived expertise of behavioral health conditions and homelessness, should contribute to planning and implementing these efforts. Strategic planning should include avenues to enhance crisis response while simultaneously expanding housing strategies for individuals who are homeless, particularly those with frequent crisis system engagement. The rollout of 988, in tandem with investment in crisis services, allows states and communities to create a more holistic, and effective crisis response system.

ADDITIONAL RESOURCES

- SAMHSA: [National Practice Guidelines for Crisis Care \[PDF\]](#)
- SAMHSA: [988 Partner Toolkit](#)
- Finding a 988 center: [Our Network : Lifeline](#)
- SAMHSA: [Guide to Psychiatric Directives \[PDF\]](#)
- WRAP: [Wellness Recovery Action Planning](#)

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Endnotes

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