

EVIDENCE-BASED RESOURCE GUIDE SERIES

# Expanding Access to and Use of Behavioral Health Services for People Experiencing Homelessness



**SAMHSA**  
Substance Abuse and Mental Health  
Services Administration

# Expanding Access to and Use of Behavioral Health Services for People Experiencing Homelessness

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## Abstract

Ending housing instability and homelessness is critical for improving public health and community well-being. Studies show much higher rates of physical health issues and mental health and/or substance use disorders among populations experiencing homelessness than among people who are stably housed. People experiencing homelessness often face a decline in their physical and mental health while sheltered or unsheltered; therefore, this is an important window for initiating mental health and/or substance use disorder treatments.

This guide provides strategies and implementation considerations for behavioral health providers and others practitioners to:

- Engage people currently experiencing homelessness
- Build strong relationships with these individuals
- Offer effective mental health and/or substance use disorder treatments
- Improve retention in recovery efforts

The guide includes four case studies to highlight strategies for providing treatment and recovery support services to people experiencing both unsheltered and sheltered homelessness. Additionally, it presents considerations for evaluation and quality improvement.



**MESSAGE FROM THE ASSISTANT SECRETARY  
FOR MENTAL HEALTH AND SUBSTANCE USE,  
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

As the Assistant Secretary for Mental Health and Substance Use in the United States Department of Health and Human Services and the leader of the Substance Abuse and Mental Health Services Administration (SAMHSA), I am pleased to present this new resource: *Expanding Access to and Use of Behavioral Health Services for People Experiencing Homelessness*.

SAMHSA is committed to improving prevention, treatment, and recovery support services for individuals with mental illnesses and substance use disorders. SAMHSA's National Mental Health and Substance Use Policy Lab developed the Evidence-Based Resource Guide Series to provide communities, clinicians, policymakers, and others with the information and tools to incorporate evidence-based practices in their communities or clinical settings. As part of the series, this guide highlights strategies for behavioral health and housing providers to conduct outreach and engage with individuals experiencing homelessness as they wait to receive stable housing. It also provides insight to help them maintain their recovery efforts once housed.

This guide and others in the series address SAMHSA's commitment to behavioral health equity, including providing equal access for all people to evidence-based prevention, treatment, and recovery services regardless of race, ethnicity, religion, income, geography, gender identity, sexual orientation, or disability. Each guide recognizes that substance use disorders and mental illnesses are often rooted in structural inequities and influenced by the social determinants of health. Behavioral health providers and community stakeholders must give attention to health equity to improve individual and population health.

I encourage you to use this guide to implement policies and programs that improve access to and use of mental health and/or substance use disorder treatment and recovery supports while individuals transition into housing.

**Miriam E. Delphin-Rittmon, PhD**

Assistant Secretary for Mental Health and Substance Use  
U.S. Department of Health and Human Services

# Evidence-Based Resource Guide Series Overview

The Substance Abuse and Mental Health Services Administration (SAMHSA), specifically its National Mental Health and Substance Use Policy Laboratory (Policy Lab), is pleased to disseminate information on evidence-based practices and service delivery models.

The Evidence-Based Resource Guide Series is a comprehensive set of modules with resources to improve health outcomes for people at risk for, experiencing, or recovering from mental health and/or substance use disorders. It is designed for providers<sup>a</sup>, administrators, community leaders, health profession educators, and others considering an intervention for their organization or community.

Expert panels of federal, state, and non-governmental participants provide input for each guide. The panels include accomplished researchers, educators, service providers, community members, community administrators, and federal and state policymakers. Members provide input based on their knowledge of healthcare systems, implementation strategies, evidence-based practices, provision of services, and policies that foster change.

A priority for SAMHSA is providing programs for individuals experiencing sheltered and unsheltered homelessness who have mental health and/or substance use disorders. Implementing new programs and practices requires a comprehensive, multi-pronged strategy. This guide is one piece of an overall strategy to implement

and sustain change. Readers are encouraged to review the [SAMHSA website](#) for additional tools and technical assistance opportunities.

[Behavioral health equity](#) is the right to access high-quality and affordable healthcare services and supports for all populations, including Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, queer/questioning and intersex (LGBTQI+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality. As population demographics continue to evolve, behavioral healthcare systems will need to expand their ability to fluidly meet the growing needs of a diverse population. By improving access to behavioral health care, promoting quality behavioral health programs and practice, and reducing persistent disparities in mental health and substance use services for under-resourced populations and communities, recipients can ensure that everyone has a fair and just opportunity to be as healthy as possible. In conjunction with promoting access to high-quality services, behavioral health disparities can be further mitigated by addressing social determinants of health, such as social exclusion, unemployment, adverse childhood experiences, and food and housing insecurity. In all areas, including serving individuals experiencing homelessness, SAMHSA is committed to behavioral health equity.

<sup>a</sup> For simplicity, the term “provider” is used throughout this guide to refer to individuals providing health care, including behavioral health services. The authors recognize that some settings may use other terms, such as clinician or practitioner.

# Content of the Guide

This guide contains a foreword and five chapters. Each chapter is designed to be brief and accessible to program administrators, clinicians, direct care staff, and community partners interested in interventions for treating individuals experiencing sheltered and unsheltered homelessness who have mental health and/or substance use disorders. This guide focuses on when a person is experiencing sheltered or unsheltered homelessness and has not yet moved into stable housing.

## FOCUS OF THE GUIDE

This guide provides an overview of the behavioral health service needs of and opportunities for individuals experiencing homelessness.

It presents five evidence-based interventions and their associated behavioral health outcomes: **medication for opioid use disorder, motivational interviewing, intensive case management, Community Reinforcement Approach, and peer support.** These approaches can assist providers with engaging people currently experiencing sheltered and unsheltered homelessness.

The guide provides examples of organizations implementing these strategies to address the behavioral health needs of individuals experiencing homelessness. It also describes evaluation approaches to assess behavioral health intervention implementations and quality improvement strategies, including whether the interventions achieved desired outcomes.

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## FW Evidence-Based Resource Guide Series Overview

Introduction to the series.

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### 1 Issue Brief

Overview of the challenge of homelessness, its definition and prevalence, the characteristics of people experiencing homelessness, and the behavioral health characteristics and service needs of this population.

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### 7 What Research Tells Us

Current evidence on five interventions to improve behavioral health outcomes for individuals experiencing sheltered or unsheltered homelessness.

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### 20 Guidance for Selecting and Implementing Evidence-Based Interventions

Considerations and practical information for providers, staff, and organizations to consider when implementing interventions to address mental health and/or substance use disorders among individuals experiencing homelessness prior to receiving stable housing.

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### 31 Examples of Organizations Implementing Evidence-Based Interventions

Descriptions of four organizations that implement the evidence-based practices from Chapters 2 and 3 for people experiencing sheltered and unsheltered homelessness.

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### 41 Resources for Evaluation

Guidance and resources for evaluating behavioral health interventions in the context of homelessness.

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## Issue Brief

Access to safe, reliable, and stable housing is a basic necessity, and directly affects physical and mental health.<sup>1</sup> People experiencing homelessness show much higher rates of physical health issues, mental health conditions, and substance use disorders (SUDs).<sup>2,3</sup> Housing instability includes experiences such as excessive cost burdens, frequent moves, and unstable doubling up with family and friends. The most extreme form of housing instability is literal homelessness: lacking a fixed, regular, and adequate nighttime residence, and staying in a shelter (emergency shelter, hotel/motel paid by government or charitable organization) or a place not intended for human habitation, such as in cars or outdoors (“the street”).

Ending housing instability and homelessness is critical to improve both community and individual well-being. Close partnerships among local governments, service providers, and community members are central to ending homelessness in the United States, as the case studies in [Chapter 4](#) highlight.

On a single night in January 2020, more than 580,000 people in the United States experienced homelessness.<sup>4</sup> The economic instability of the ensuing years exacerbated the homelessness crisis, but also brought unprecedented resources to communities. Specifically, the House America federal initiative of 2021 leveraged funds from the American Rescue Plan Act and Coronavirus Aid, Relief, and Economic

Security (CARES) Act to provide historic resources for state, tribal, and local leaders to build on [Housing First](#) principles to rapidly rehouse and develop additional housing for people experiencing homelessness.

### Housing First

[Housing First](#) is an effective approach to reducing homelessness in the United States. The philosophy of Housing First is to connect individuals and families experiencing homelessness quickly and successfully to stable housing without preconditions and barriers to entry, such as sobriety, treatment for mental health and/or substance use disorders, or service participation requirements. Voluntary supportive services are offered to maximize housing stability and prevent returns to homelessness as opposed to addressing predetermined treatment goals prior to stable housing entry.

Importantly, a Housing First approach does not require that individuals receive treatment for mental health and/or substance use disorders as a condition to enter or retain housing. Supportive services are offered, and it is up to the individual to decide whether to accept them.

Readers will find resources in [Chapter 3](#) on [behavioral health](#) services for individuals in Housing First and other housing programs.

However, the supply of affordable housing is still inadequate to meet the needs of those experiencing homelessness.<sup>5</sup> Wait times for placement into permanent housing can be long, ranging from a few months to several years. The recent influx of new resources may reduce wait times, but there remains a period during which people are on the street and in shelters. While people wait for a housing placement, their physical and mental health conditions often worsen.<sup>6,7</sup> In some cases, a person’s health may decline to the point where affordable housing alone, without additional support, becomes less likely to be successful and health-promoting.




The period prior to moving into stable housing, therefore, is an important window for offering services across the [social determinants of health](#). These services include primary care, mental health care, and SUD treatment, and require multi-system coordination.

This guide focuses on programs and practices that demonstrate success in improving mental health and [substance use](#) outcomes during the often-lengthy period of homelessness prior to housing placement. These practices include brief mental health counseling, medication for opioid use disorder (MOUD), case management, and social and [recovery support services](#). This work requires engaging people both “where they are” in terms of where they live and sleep at night, and, following [harm reduction](#) principles, “where they are” in terms of their use of substances.<sup>8</sup>

## Defining Homelessness

Homelessness is often categorized by shelter status, the amount of time an individual or family has experienced homelessness,<sup>9,10</sup> and the family situation of those experiencing homelessness. These categories are neither mutually exclusive nor exhaustive.

### Categories of Homelessness

 <b>Shelter Status</b>	 <b>Temporality</b>	 <b>Family Situation</b>
<ul style="list-style-type: none"> <li>• <b>Sheltered homelessness</b> refers to people experiencing homelessness who are staying in an emergency shelter, transitional housing, or safe havens.</li> <li>• <b>Unsheltered homelessness</b> refers to people experiencing homelessness whose primary nighttime location is a public or private space not designated for, or typically used as, a regular sleeping accommodation for people (e.g., the streets, vehicles, parks, transit stations, abandoned buildings).</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Episodic homelessness</b> refers to periods where individuals “shuttle in and out of homelessness, or the mediating institutions that house them” (common among all people experiencing homelessness, including those individuals struggling with health issues and/or substance use disorders (SUDs)).</li> <li>• <b>Chronic homelessness</b> refers to homelessness lasting at least one year of the past three years and refers to individuals who have a disabling condition, such as a serious mental illness (SMI), SUD, or physical disability. Most people experiencing chronic homelessness are individuals rather than families.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Family homelessness</b> refers to families (that is, at least one parent with a child under the age of 18) experiencing homelessness together. Families may experience forms of extreme housing instability other than sheltered or unsheltered homelessness. For example, they may be unstably doubled up with other families or staying temporarily in hotels or motels.</li> <li>• <b>Youth homelessness</b> refers to people under the age of 25 who are not accompanied by a parent or guardian and are not themselves parents with accompanying children. Youth may become homeless after being asked, told, or forced to leave home by parents/caregivers. Runaway youth are those who have left home without parent/caregiver permission. “Systems youth” are those who experience homelessness after aging out of the foster care system or exiting the juvenile justice system.</li> <li>• <b>Individual homelessness</b> refers to a person who is not part of a family with children during an episode of homelessness. Individuals may be homeless by themselves or together with other adults.</li> </ul>

**Sources:**

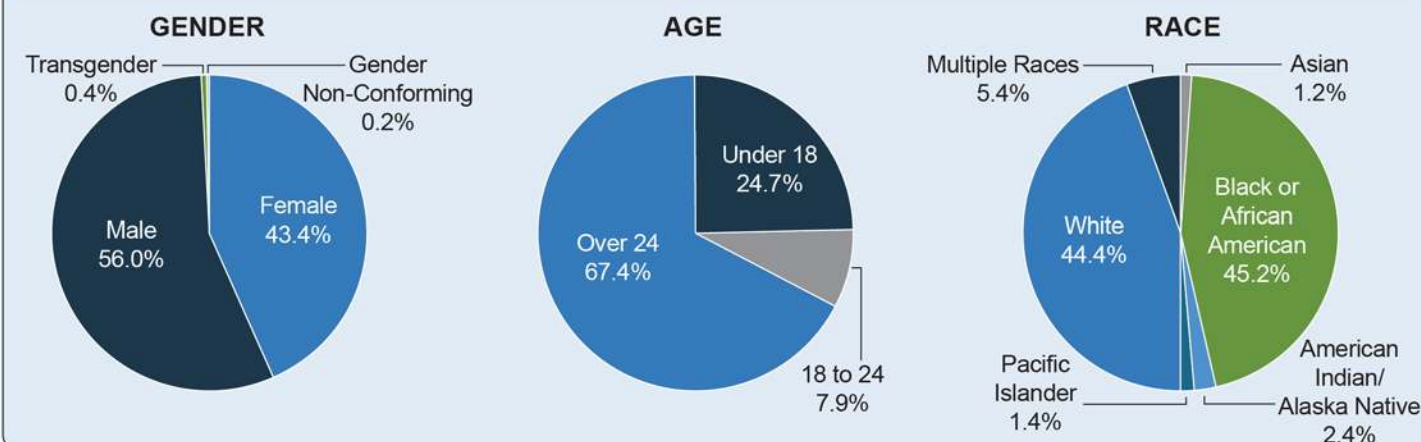
Kuhn, R., & Culhane, D. P. (1998). Applying cluster analysis to test a typology of homelessness by pattern of shelter utilization: Results from the analysis of administrative data. *American Journal of Community Psychology*, 26(2), 207-232.

Institute for Children Poverty and Homelessness. (2017). *FAQ about family homelessness*.

U.S. Department of Housing and Urban Development. (2022). *The 2021 Annual Homeless Assessment Report (AHAR)* to Congress.

Youth.gov. (n.d.). *Federal definitions*.

## Demographics of People Experiencing Sheltered Homelessness, 2021



Source:

U.S. Department of Housing and Urban Development. (2022). *The 2021 Annual Homeless Assessment Report (AHAR) to Congress*.

## Prevalence of Homelessness and Characteristics of People Experiencing Homelessness

As many as 4.2 percent of the U.S. population will be homeless at some point during their lifetime.<sup>11</sup> Approximately 326,000 people experienced sheltered homelessness in the United States on a single night in January 2021.<sup>12</sup> As noted above, 580,466 people experienced any homelessness (sheltered and unsheltered) on a single night in January 2020, with just over 60 percent staying in sheltered locations.<sup>4,b</sup>

While a common depiction of homelessness in the media is a single individual, 40 percent of people experiencing sheltered homelessness are families.<sup>12</sup> Families experiencing homelessness have specific and often urgent needs, such as services to address intimate partner violence, child support, childcare, education, and employment. (Note: The practices described later in this guide can apply to parents and couples but are not designed specifically to address family challenges.)

Homelessness disproportionately affects certain groups of individuals. For example, youth who identify as



lesbian, gay, bisexual, transgender, queer/questioning, and intersex (LGBTQI+) make up approximately 10 percent of the overall youth population but 28 percent of the youth population experiencing homelessness or housing instability.<sup>13,14</sup> Transgender youth are at significantly greater risk of being homeless or housing-unstable.<sup>15</sup> Homelessness and housing instability among LGBTQI+ youth are often accompanied by additional risks, including substance use, experiencing violence, and risky sexual behaviors, including unprotected sex and “survival sex” (i.e., sex in exchange for money, shelter, or other basic needs).<sup>16-18</sup> LGBTQI+ youth who experience homelessness or housing instability are two to four times more likely than their housing-stable LGBTQI+ peers in the broader LGBTQI+

<sup>b</sup> Counts of people experiencing unsheltered homelessness are not available for 2021 since many communities did not conduct them in January 2021 because of COVID-19 transmission risk.

community to report anxiety, depression, self-harming behaviors, suicidal ideation, or a suicide attempt.<sup>19</sup> They also have higher rates of reported trauma and experience over twice the rate of early death when compared to heterosexual youth experiencing homelessness.<sup>20</sup>

Among adults, the National Center for Transgender Equality reports that 20 percent of transgender adults have experienced homelessness during their lifetime.<sup>21</sup> Similar to LGBTQI+ youth, transgender adults experience particular challenges; they are more likely to be living in unsheltered settings than cisgender adults, due to multiple factors.<sup>22</sup> For example, in spite of efforts to increase education and sensitivity of shelter staff, the shelter system has historically been highly prejudicial against transgender individuals. Shelters may not allow transgender women access to women-only settings, may be physically unsafe, and may not sufficiently protect them or offer privacy.<sup>23</sup> In some cases, transgender individuals may experience discrimination in obtaining housing,<sup>24</sup> which can both be a contributing factor to becoming homeless and make exiting homelessness more challenging.

The prevalence of homelessness also varies by race.<sup>c</sup> African Americans make up more than 40 percent of all people experiencing sheltered homelessness, despite comprising only about 13 percent of the U.S. population. Similarly, American Indian/Alaska Native people account for about 4 percent of the sheltered homeless population, but only 1 percent of the U.S. population.<sup>12,25</sup> Such overrepresentation of persons of color in the homeless population reflects the role of [structural racism](#) as a driver of homelessness in the United States.<sup>5</sup>

## Homelessness and Structural Racism

For many people, the underlying causes of homelessness can be linked to structural racism, a system that fosters racial discrimination through often mutually reinforcing macro-level policies.<sup>26</sup> Longstanding systemic inequities and systems of stratification make people of color more predisposed to certain pathways into homelessness. Drawing from past commentary on this topic, we note the following aspects for consideration:

<sup>c</sup> The U.S. Census Bureau [defines race](#) as a person's self-identification with one or more social groups based on ancestral region of origin. Information on race is collected to make funding decisions and understand disparities in housing, education, employment, health care, and other sectors. While there are not biologically distinct "races," there are biological traits that are more common in certain races than others.

- **Racial Economic Inequality:** Racial disparities in wealth, earnings, and unemployment are well-documented and persistent. In 2019, the median income in a Black household was only 61 cents for every dollar earned in a White household.<sup>27</sup> Historically, communities of color have also been systematically excluded from means of wealth accumulation. For example, redlining and unjust lending practices suppressed homeownership in these communities throughout the twentieth century. As a result, many households of color lack resources to manage economic crises<sup>5</sup> or build buffers that reduce risk of homelessness in the future.
- **Residential Segregation and Housing Discrimination:** A long history of discriminatory laws and practices has resulted in racial segregation, particularly in urban centers.<sup>26</sup> Households of color are more likely to live in under-resourced neighborhoods where the risk of homelessness is much greater (e.g., due to a lack of social supports, barriers to health care, overcrowding, and more).<sup>5</sup> Decades of research has documented racial discrimination throughout every stage of the rental market,<sup>28</sup> people of color pay more for identical housing units in the same neighborhood compared to White renters.<sup>29</sup> In addition, communities of color experience higher rates of policing, often due to racial profiling, which can create a cycle of criminal justice system involvement and potential homelessness.<sup>30</sup>
- **Homeless Response System and Homelessness Interventions:** Racism, discrimination, and unconscious bias in public systems constitute ongoing drivers of homelessness, including within the homeless response system itself. Assessment tools used to prioritize services among homeless populations can be biased.<sup>31</sup> Service systems designed to focus on particular contributors to homelessness—such as mental health and substance use conditions—may disproportionately help White populations in which those clinical issues are more often a driver of homelessness, while not sufficiently addressing the structural drivers that more often impact people of color.

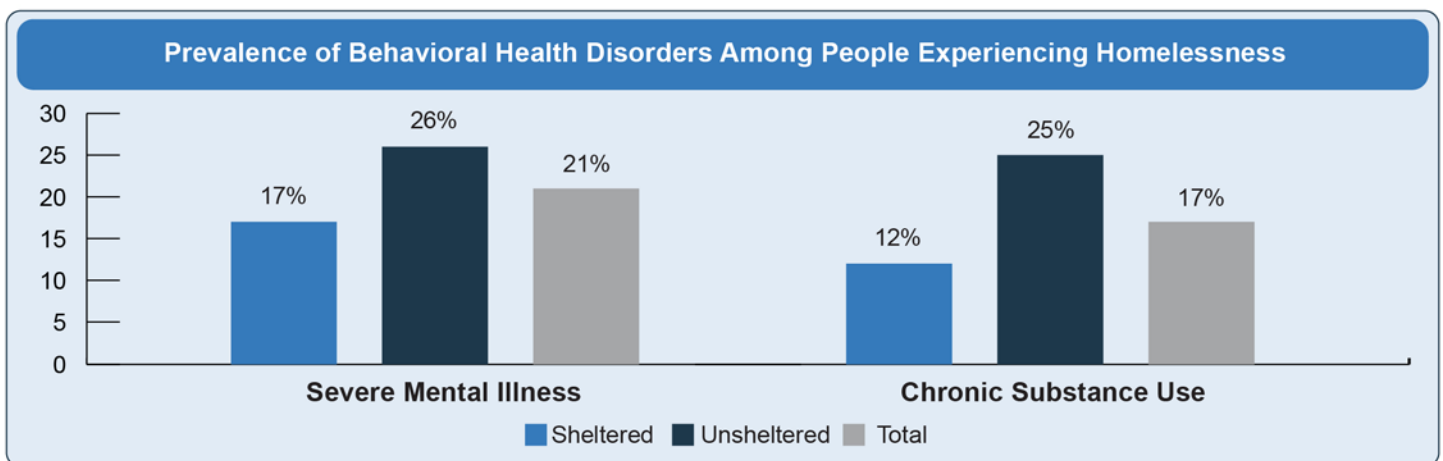
# Behavioral Health Characteristics and Service Needs of People Experiencing Homelessness

The behavioral health needs of people experiencing homelessness vary. People experiencing homelessness are more likely to have a history of trauma than people who are stably housed, which is associated with a greater risk of mental health problems.<sup>32</sup> Over 20 percent have a [serious mental illness](#) (SMI),<sup>d</sup> although the true prevalence may be closer to 30 percent or even higher.<sup>33,34</sup> The prevalence rate of psychotic disorder or schizophrenia among people experiencing homelessness is between 10 and 21 percent,<sup>32</sup> and approximately 11 percent may have bipolar disorder.<sup>35</sup> In 2020, 5.6 percent of adults aged 18 or older had SMI in the past year.<sup>36</sup> Substance use is also common; an estimated 17 to 33 percent of people experiencing homelessness received treatment for alcohol or drug use.<sup>2,34,37</sup> Between 20 and 50 percent of individuals experiencing homelessness are estimated to have co-occurring mental health disorder and SUD.<sup>38</sup>

Alcohol and marijuana use are especially prevalent among youth and young adults experiencing homelessness;<sup>39</sup> older adults (>60 years) may be more likely to use cocaine and heroin.<sup>40</sup> As indicated below, severe mental illness and chronic substance use prevalence rates are highest among people experiencing unsheltered homelessness.<sup>34</sup> These populations may benefit from a harm reduction approach to addressing substance use.<sup>41-43</sup>

Mental health and substance use are often intertwined with peoples' [lived experiences](#); a history of trauma can be associated with increased substance use.<sup>44-46</sup> Longer periods of homelessness are similarly associated with lower rates of [recovery](#) and higher rates of psychiatric distress.<sup>47</sup> Individuals with mental health disorders and/or SUDs are also at higher risk for relapse<sup>48</sup> and subsequent housing instability.<sup>49</sup> Overall, homelessness is associated with a 1.5 to 11.5 times greater risk of mortality.<sup>50</sup> As a result, it is estimated that people experiencing homelessness die 12 years earlier, on average, than the general population.<sup>6</sup>

People experiencing homelessness face additional barriers to accessing needed services and care, such as no identification or other documentation, limited



**Source:**

U.S. Department of Housing and Urban Development. (2020). *CoC Homeless Assistance Programs, Homeless Populations and Subpopulation Data*.

**Note:**

HUD defines severe mental illness as mental health problems that are expected to be of long-continued and indefinite duration and that substantially impair the person's ability to live independently. HUD defines chronic substance use as alcohol use, illicit drug use (In the original report, HUD uses the term "abuse."), or both, that is expected to be of long-continued and indefinite duration and that substantially impairs the person's ability to live independently.

<sup>d</sup> Also referred to below as *severe mental illness*.

transportation, and a lack of health insurance and other resources. This population also has pressing needs to find daily food, shelter, and safety, and may face shame, stigma, and discrimination when seeking services.<sup>51-53</sup> Consequently, nearly three-quarters of people experiencing homelessness have unmet needs for care, and rates of unmet needs are 6 to 10 times higher than in the general population.<sup>54</sup> People aged 65 and older who experience homelessness have even greater unmet needs for behavioral health treatment.<sup>55</sup>

Outreach serves as a bridge for creating access for someone experiencing homelessness to obtain the resources they need to improve their well-being.

Given these barriers, individual [outreach](#) services are critical for providing health, mental health, and substance use treatment services to individuals experiencing homelessness. Outreach is a broad term that refers to serving individuals outside a physical

structure—most typically, in unsheltered settings. Effective outreach meets people where they are, and respects their choice to engage in services or not.<sup>56</sup>

As highlighted in all four case studies examined in [Chapter 4](#), when implemented effectively, systematic and coordinated outreach can provide individuals with information about what services are available and how to access them; in many cases, it can also provide those services. For example, “street medicine” programs provide medical care to people in unsheltered settings, often making use of a mobile health van to provide primary care services comparable to what is available in a clinic. Similarly, case managers, peer specialists, counselors, and other staff can use outreach to build trust and relationships with people in locations where they feel comfortable. Like most aspects of meeting the needs of individuals experiencing homelessness, close coordination and collaboration across organizations are critical components of successful outreach.

## Harm Reduction

Harm reduction is a practical and transformative approach that incorporates community-driven public health strategies—including prevention, risk reduction, and health promotion—to empower individuals and their families with the choice to live healthy, self-directed, and purpose-filled lives. It seeks to reduce the harmful impact of substance use and other risky behaviors through meeting people where they are, engaging with them, and providing support. By viewing substance use on a continuum, incremental changes can be made, allowing for risk reduction that best suits a person’s individual goals and motivations. This approach opens the door for people who use substances and want to make positive changes in their lives but do not find success with the more traditional options currently available to them. Harm reduction approaches may be especially critical for individuals experiencing homelessness. The underlying philosophy of the approach is to promote change without judgment, coercion, or requirements for sobriety.<sup>57</sup>

One important harm reduction strategy is the use of naloxone and providing naloxone training to staff who work with individuals who are homeless. As an opioid antagonist, naloxone counters the effects of an opioid, such as morphine, fentanyl, or heroin, and restores normal breathing in an individual who has overdosed on an opioid.

In 2021, as the overdose epidemic continued to increase and the evidence base around harm reduction practices grew, Congress allotted \$30 million to SAMHSA via the American Rescue Plan Act to fund grant programs that enhance overdose and other types of prevention activities to help control the spread of infectious diseases and the consequences of such diseases for individuals with or at risk of developing SUDs. Through SAMHSA’s Harm Reduction Grant Program, organizations distribute opioid overdose reversal medication (e.g., naloxone) to individuals at risk of overdose; connect individuals at risk for or with SUD to overdose and/or health education and counseling; and encourage individuals to take steps to reduce the negative personal and public health impacts of substance use or misuse. Resources on harm reduction are available from [SAMHSA](#).



## What Research Tells Us

This chapter explores the evidence for improving access to and use of mental health and/or substance use treatment and recovery supports while individuals transition into housing. As highlighted in [Chapter 1](#), services offered while individuals are on the street or residing in shelters and other transitional settings may be beneficial for addressing immediate needs, as well as laying the foundation for continued treatment and recovery once individuals are housed.

### Program Selection

This guide summarizes the results of a targeted literature search to identify interventions, approaches, or models that have effectively been used to improve behavioral health service engagement and recovery among individuals experiencing sheltered or unsheltered homelessness. To identify approaches, the search strategy began with a broad review of systematic reviews of populations experiencing different types of homelessness (chronic, sheltered, unsheltered) and behavioral health topics (substance use, mental illness, co-occurring disorders, harm reduction). All identified citations were systematically reviewed and examined to identify studies that discussed one or more interventions. For an approach to be considered for inclusion, at least one study needed to demonstrate a positive outcome related to behavioral health, and the intervention or approach needed to occur with individuals who were experiencing homelessness who were not already housed.

Based on a review of potential interventions, SAMHSA's National Policy Lab, CSAT/CMHS staff, and subject matter experts selected five treatment approaches and practices with evidence of effectiveness for individuals experiencing homelessness:

1. Medication for Opioid Use Disorder (MOUD)
2. Motivational interviewing (MI)
3. Intensive case management
4. Community Reinforcement Approach (CRA)/Adolescent Community Reinforcement Approach (A-CRA)
5. Peer support

Resources for each of these appear in [Chapter 3](#), additional detail on the review process is described in [Appendix 2](#), and [Appendix 3](#) details the studies included in this guide.

This chapter describes each of the above five interventions and the positive behavioral health outcomes (e.g., mental health disorder and/or SUD service engagement and use) achieved for individuals experiencing homelessness. The chapter concludes with a brief discussion of the limitations of the evidence base.

While the five interventions can be readily used with individuals who are part of a family unit (e.g., parents or a couple who are homeless), the research studies included in the review were conducted with single adults

and adolescents/young adults. None of the approaches is explicitly family-based, nor are the interventions intended to address complex system dynamics that are often incorporated into family therapy.

### Defining Recovery

SAMHSA defines [recovery](#) as a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential.<sup>62</sup> Recovery is supported through four dimensions:

1. **Health:** overcoming one's disease(s) or symptoms and making informed, healthy choices that support physical and emotional well-being
2. **Home:** having a stable and safe place to live
3. **Purpose:** conducting meaningful daily activities, such as employment, school, volunteerism, family caretaking, or creative endeavors, and having the independence, income, and resources to participate in society
4. **Community:** having relationships and social networks that provide support, friendship, love, and hope

Treatment approaches and practices in this chapter focus on promoting positive change and providing support while individuals experiencing homelessness wait to receive stable housing.



## Medication for Opioid Use Disorder (MOUD)

### Overview

For individuals experiencing homelessness who have certain substance use disorders (SUDs), medication for opioid use disorder (MOUD) and medication for alcohol use disorder (MAUD) are critical components of recovery, decrease deaths by overdose, and are supported by research.<sup>58,59,60,61</sup> MOUD and MAUD are often provided in combination with behavioral interventions and practices, such as the four additional interventions described in this chapter.<sup>c</sup>

MOUD has been shown to reduce opioid use and related symptoms, block opioid effects on the brain, and relieve physiological cravings.<sup>63,64</sup> The three FDA-approved medications for MOUD are buprenorphine, methadone, and naltrexone. Treatment settings vary based on which medication is used. [Opioid treatment programs](#) (OTP) offer community-based outpatient addiction treatment for individuals diagnosed with an OUD to alleviate the adverse medical, psychological, or physical effects of opioid addiction.

Learn more about MOUD and MAUD on [SAMHSA's website](#) and in guides on [treating concurrent substance use](#) among adults and tools for [prescribing and promoting buprenorphine](#) in primary care settings.

<sup>c</sup> Throughout this guide, we use the term *intervention* for consistency, acknowledging that the terms *practice* and *approach* may be more appropriate in some cases.

Intervention	Description of Intervention
<b>Medication for Opioid Use Disorder</b>	Medication for Opioid Use Disorder (MOUD) is the use of a medication that targets the brain, in combination with counseling and behavioral therapies, to provide a “whole-patient” approach to the treatment of opioid use disorders. The three medications approved by the FDA are methadone, naltrexone, and buprenorphine.
<b>Motivational Interviewing</b>	Motivational interviewing (MI) is a collaborative approach that uses a goal-oriented style of communication, allowing for the client to direct the change rather than telling the client what they need to do. MI is typically provided in conjunction with other service modalities. MI is a short-term intervention that has no prescribed duration; sessions typically last 30 to 60 minutes.
<b>Intensive Case Management</b>	Intensive case management is a service modality in which providers broker services and support clients in identifying and accessing needed supports by making linkages and warm handoffs to mental health and/or substance use disorder treatment, housing, and wraparound support services. Intensive case management is not time-limited and often continues after an individual is stably housed.
<b>Community Reinforcement Approach (CRA) / Adolescent CRA</b>	CRA is an approach developed with adults and adapted for use with youth experiencing homelessness to encourage involvement in alternative non-substance-related social activities, reduce substance use, and improve mental health and well-being. CRA can accompany other service modalities. CRA is not explicitly time-limited; it typically includes weekly sessions for approximately 10 weeks.
<b>Peer Support</b>	Peer support services encompass a range of activities and interactions between people who share similar experiences of being diagnosed with mental health conditions, substance use disorders (SUDs), or both. Individuals who provide peer support may be referred to as peer navigators, peer support workers, peer specialists, peer recovery coaches, peer recovery specialists, trained peers, peer supporters, or simply peers. In the context of this guide, peers are individuals who have successfully recovered from mental health disorders and/or SUDs and/or previously experienced homelessness.

### Outcomes Associated With MOUD

Eight observational studies demonstrated that for unstably housed individuals, MOUD was associated with:

- Decreased opioid use, according to urine drug tests<sup>60,65</sup>
- Decreased use of unprescribed controlled substances\*<sup>65</sup>
- Decreased rates of overdose<sup>65</sup>
- Continued engagement in treatment<sup>58,60,66-68,70</sup>
- Continued engagement in recovery<sup>69</sup>
- Increased employment<sup>60,65</sup>
- Continued attendance of additional behavioral health services, such as substance use counseling and mutual-help groups<sup>60,70</sup>
- Lower mortality risk\*<sup>66</sup>

\*Denotes significant result (p<0.01)

OTPs must be certified by SAMHSA and accredited by an independent, SAMHSA-approved accrediting body. Whereas OTPs must deliver methadone, various settings can deliver buprenorphine and naltrexone, including physician offices and clinics, mobile units, outpatient treatment programs, residential treatment programs, and OTPs.<sup>63</sup>

This review identified eight studies of MOUD with individuals experiencing homelessness; six were retrospective chart review studies<sup>58,60,65-68</sup> and two were descriptive reports.<sup>69,70</sup>

### Typical Settings

Studies included in this evidence review achieved success both by:

- Integrating MOUD programs into existing settings where people experiencing homelessness receive services
- Developing street-based programs through these existing settings

One study provided shelter-based opioid treatment at a family motel-based shelter in Massachusetts.<sup>65</sup> Two other studies integrated MOUD services into a needle exchange program<sup>70</sup> and a residential recovery program for men experiencing homelessness.<sup>69</sup> The MOUD program at the residential recovery center also provided medication refills through telehealth services.<sup>69</sup> Three studies provided integrated MOUD services in office settings: an academic medical center,<sup>60</sup> a health care for the homeless program,<sup>66</sup> and a federally qualified health center.<sup>67</sup> Three other studies involved mobile MOUD: one study engaged patients with peer outreach workers;<sup>58</sup> and another engaged patients in geographic areas with the highest rates of fatal overdoses.<sup>68</sup>

## Demographic Groups

MOUD is effective across genders, ages, races, ethnicities, and other demographic characteristics. Programs cited in the evidence review provided MOUD to clients<sup>f</sup> who mainly self-identified as White, African American, or Hispanic/Latino.<sup>58,65-70</sup> MOUD can also be provided to adults of varying ages; studies cited in this guide included adults aged 25 to 60 years old.<sup>65,70</sup> One study provided MOUD specifically to men experiencing homelessness,<sup>69</sup> while another had a client population that was mostly female, since it studied families experiencing homelessness and most of those families had female heads of household.<sup>65</sup> In one of the studies, clients reported co-occurring mental disorders; seven of the ten participating clients reported depression or bipolar disorder, and all clients reported having pain and anxiety.<sup>65</sup>

## Provider Types

In a study on shelter-based opioid treatment, the program team included one physician, one nurse, two case managers, and one behavioral health clinician;<sup>65</sup> a physician and a nurse care manager are typically the minimum staff required to provide MOUD services.<sup>60</sup> In another study, a staff physician communicated with clients through a secure online portal and provided refills through a telehealth intervention.<sup>69</sup> One study of a buprenorphine detoxification program paired the intervention with peer group support and meetings with a certified substance use counselor.<sup>70</sup>

## Intensity and Duration of Treatment

The intensity and duration of MOUD can vary, based on client history of opioid use, medication prescribed, and progress made. Typically, MOUD treatments last a year or longer. In two retrospective studies analyzing patients who received buprenorphine prescriptions for at least three months, the mean lengths of treatment were 7.4 months and 9 months, with a range from 3 to 12 months.<sup>60,65</sup> In another study on a buprenorphine detoxification intervention located in a needle exchange program, the intervention lasted 22 days, with buprenorphine detoxification occurring for 15 days.<sup>70</sup> In another study, the MOUD pilot program at a residential recovery center lasted four months.<sup>69</sup>

## Motivational Interviewing (MI)

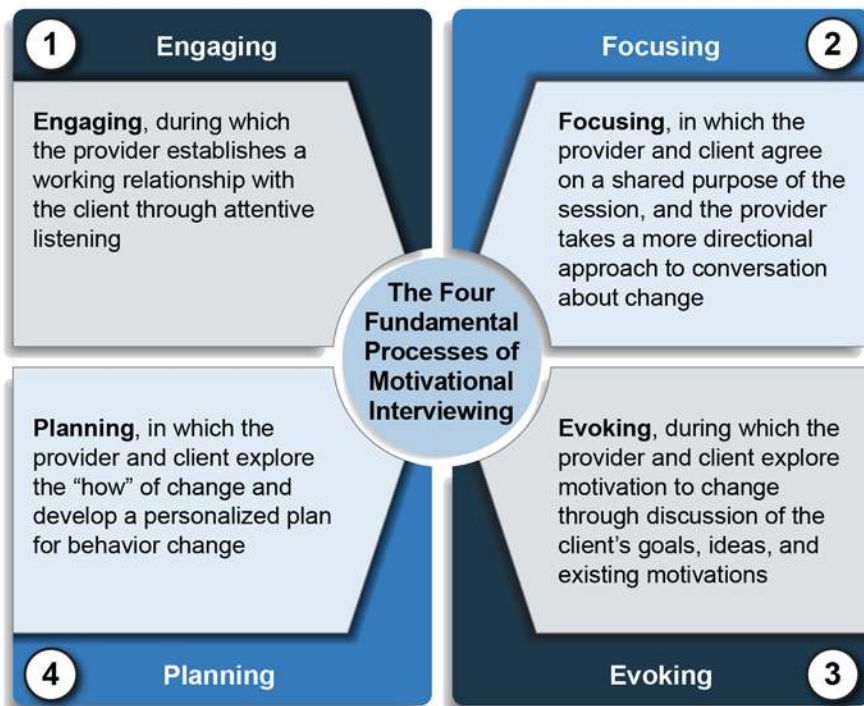
### Overview

MI is a client-centered counseling approach that helps individuals overcome ambivalent feelings and insecurities and generate motivation to change undesired behaviors and reduce or stop unhealthy lifestyle choices.<sup>71</sup> MI can complement other treatment approaches and promote engagement with those services.<sup>72</sup> It helps individuals with a variety of presenting problems, including mental health disorders and/or SUDs. MI can move individuals towards recovery and engage them in treatment before and while working toward a stable housing placement. The approach emphasizes empathy and reflective listening, identification of discrepancies between client goals and current behaviors, and a non-confrontational style that challenges assumptions about norms but leaves decision-making responsibility with the client.<sup>73</sup> Information about MI implementation is given in [Chapter 3](#).

Across a range of populations, MI alone has been found to have modest but positive effects on alcohol and marijuana use outcomes.<sup>74,75</sup> MI is significantly associated with improved engagement and intention to change, and could possibly boost client confidence in their ability to change.<sup>74</sup> MI has also been shown to improve treatment outcomes when used as pretreatment or combined with other therapies.<sup>76,77</sup>

<sup>f</sup> “Client” is used throughout this guide to refer to individuals receiving behavioral health services. The authors recognize that, while some professional roles or settings may use this term exclusively, other organizations, professional roles, or settings may use other terms, such as patient.

## The Four Fundamental Processes of Motivational Interviewing



**Source:**

Motivational Interviewing Network of Trainers. (2021). *Understanding Motivational Interviewing*.

This review identified five studies of MI with individuals experiencing homelessness, four of which were randomized controlled trials (RCTs), and the fifth a qualitative outcomes study. Three studies compared MI interventions with usual care or other control conditions.<sup>73,78,79</sup> A fourth study compared MI interventions with CRA and Ecologically-Based Family Therapy (EBFT).<sup>80</sup> Of the five studies:

- One examined a four-session MI intervention<sup>79</sup>
- Two examined brief MI approaches<sup>73,78</sup>
- One examined a four-session MI intervention focused on HIV/STI transmission and the effects of alcohol and other drug use<sup>79</sup>
- One examined a three-session MI intervention focused on alcohol and drug use, HIV risk behavior, and interpersonal violence (referred to as “The Power of You” program)<sup>81</sup>

### Typical Settings

A wide range of healthcare settings use MI, from primary care clinics to general or specialized hospitals, other outpatient settings, and community-based health centers. Two programs delivered MI at drop-in centers,<sup>78,79</sup> while the program in one study provided MI at a homeless shelter.<sup>81</sup> Another study applied MI at field offices established for the study, which were located in community areas.<sup>73</sup> One study of MI for runaway youth used the intervention in participants’ family homes.<sup>80</sup> Studies recruited participants from homeless shelters,<sup>80,81</sup> drop-in centers,<sup>78,79</sup> and street outreach.<sup>73</sup> All the reviewed studies were conducted in the United States.

### Outcomes Associated With MI

Two studies demonstrated that for unstably housed youth and young adults, an MI intervention was associated with:

- Reduced frequency of alcohol use and increased readiness and confidence to reduce or quit other drug use—such as crack, cocaine, heroin, methamphetamine, ecstasy, hallucinogens, inhalants, and over-the-counter medicines—at three-month follow-up<sup>79</sup>
- Reduced prevalence of participants using cocaine, amphetamines, or opiates at one month after treatment<sup>\*73</sup>
- Increased service utilization, including number of drop-in center visits and use of additional services (e.g., case management, recreation activities, life skills classes) at one month after treatment<sup>\*78</sup>
- Reduced frequency of unprotected sexual events among those who reported having two or more sexual partners in the past three months, at three-month follow-up<sup>79</sup>

One quantitative study found that MI participation was associated with a reduction in substance use over a two-year span.<sup>80</sup> A qualitative study reported that MI participants provided positive feedback and high satisfaction at the end of a three-session MI intervention.<sup>81</sup>

*\*This effect was no longer significant at the three-month follow-up period.*

## Demographic Groups

MI is intended for use across genders, ages, races, ethnicities, and other demographic characteristics. Studies examined for this review assessed MI interventions used with runaway youth between the ages of 12 and 18 years old, and young adults experiencing homelessness between the ages of 18 and 25. In two studies, 67 and 79 percent of participants identified as heterosexual.<sup>73,79</sup> In three of these five studies, participants were recruited if they reported illicit substance use and/or at least one binge drinking episode in the past month.<sup>73,78,80</sup> In two studies, the majority (>80 percent) of participants reported recent alcohol and marijuana use, about half reported amphetamine use, and more than a quarter reported cocaine and opiate use.<sup>73,78</sup> Another study categorized about half of participants as “heavy drinkers” or “frequent heavy drinkers.”<sup>79</sup> Two studies had a majority White sample;<sup>73,78</sup> while two others had a predominantly African American sample.<sup>80,81</sup> One sample was predominantly male,<sup>79</sup> while another consisted of only women.<sup>81</sup>

## Provider Types

MI is intended for use by a wide variety of providers, including primary care and behavioral health professionals, peers, and other service providers and counselors. Training on MI is available for clinicians and non-clinicians alike, including those with minimal to no formal training in counseling or therapy, through organizations such as [Motivational Interviewing Network of Trainers \(MINT\)](#). Providers include bachelor’s-level project staff,<sup>79</sup> study counselors under the supervision of experienced MI trainers,<sup>73,78</sup> graduate couples/family therapy students,<sup>80</sup> and homeless shelter workers.<sup>81</sup>

## Intensity and Duration of Treatment

MI does not have a prescribed length or duration, but it is typically considered a short-term intervention and often integrated as a counseling approach in a larger intervention framework.<sup>82</sup> The duration of MI interventions used in the studies reviewed above varied from one to four sessions, with individual sessions typically lasting between 30 and 60 minutes.

# Intensive Case Management

## Overview

Intensive case management involves providers brokering services in the community and supporting clients experiencing homelessness in identifying and accessing needed assistance by offering linkages and warm handoffs to mental health and/or SUD treatment, housing, and wraparound support services.<sup>83</sup> Intensive case management was adapted from two earlier



community models of care: [assertive community treatment](#) (ACT, which is described at the [end of this chapter](#)) and case management.<sup>84</sup> Intensive case management is intended for individuals who may not require the level of services provided through ACT models, which involves 24/7 service provision from multiple providers. The primary difference between traditional case management and intensive case management is that intensive case management involves smaller caseloads (fewer than 20), which enables providers to achieve desired outcomes through increased interaction with the client (i.e., engagement with and use of mental health and/or SUD treatment services that support recovery).<sup>84</sup> More information about [implementation of intensive case management](#) for individuals experiencing homelessness appears in [Chapter 3](#).

Treatment of mental health disorders and/or SUDs among those experiencing sheltered or unsheltered homelessness represents a significant case management challenge. There is limited housing stock availability in general, as well as specifically for people who have

mental health disorders and/or SUDs. Identifying and evaluating resources is time-consuming, and collaboration with other community agencies is essential for success—though also complex. Despite these challenges, intensive case management is often a critical aspect of support prior to and following housing placement.

This review focuses specifically on intensive case management provided for people experiencing homelessness and who have needs for mental health and/or SUD treatment. Two studies were identified, one a qualitative study and the other a pre-post study.

### Typical Settings

For individuals experiencing homelessness, intensive case management can be provided in a variety of settings, including inpatient and outpatient treatment facilities, shelters, jails/prisons, the street, or even the client's residence once stably housed. In the studies reviewed here, clients were recruited from county jails,<sup>85</sup> emergency shelters, and on the street.<sup>86</sup>



## Outcomes Associated With Intensive Case Management

Two non-experimental studies demonstrated that for unstably housed individuals, intensive case management was associated with:

- Increased retention in behavioral health treatment services<sup>85</sup>
- Reduced psychiatric symptoms, including symptoms of depression or anxiety, hallucinations, suicidal ideation, suicide attempt, taking prescribed psychiatric medication, and the extent to which one is affected by psychiatric symptoms<sup>86</sup>
- Reduced alcohol and other substance use<sup>86</sup>
- Reduced number of days of homelessness<sup>86</sup>
- Outcomes for both studies were assessed one year after the intervention.

While these studies showed improved behavioral health and housing outcomes, it is important to note that they were not randomized trials; therefore, these outcomes cannot be causally attributed to the intervention.

## Demographic Groups

Intensive case management can be used with all genders, races, ethnicities, and ages. One of the studies reviewed here used intensive case management with men and women who were young (18 to 34 years), middle-aged (35 to 54), and older (55+).<sup>86</sup> The study identified clients as experiencing homelessness at time of enrollment. In this study, 41 percent of young and middle-aged women and 60 percent of older women identified as White, whereas 47, 49, and 28 percent of young, middle-aged, and older women, respectively, identified as African American.<sup>86</sup> Intensive case management may be less helpful when an individual has fewer needs, in that they may not require the level of support offered through the intensity of engagement.<sup>87</sup>

## Provider Types

Providers of intensive case management typically have backgrounds in social work, psychology, or human services. In the studies reviewed here, organizational staff and other providers in the community, including outreach workers, case managers, and other behavioral health providers, delivered the intensive case management.

## Intensity and Duration of Treatment

Intensive case management is not a time-limited intervention but can continue to be beneficial even after an individual is stably housed. While the reviewed studies did not specify the intensity of the intensive case management, all clients received services described as an “intensive case management intervention.”

## Community Reinforcement Approach (CRA)

### Overview

CRA was originally developed for treatment of alcohol use disorder.<sup>88</sup> This behavioral health intervention includes multiple components that aim to identify environmental and contextual factors that reinforce target behaviors and to build new, positive reinforcers that result in healthier lifestyles.<sup>89</sup> CRA includes components focused on participants’ substance use, social and job skills (e.g., communication, problem-solving), and movement towards recovery. There is a tailored version of CRA—the Adolescent Community Reinforcement Approach (A-CRA)—which targets adolescents with substance use issues and involves caregivers in treatment; it is the focus of a case study in [Chapter 4](#). While not covered in this guide, there is also an adaptation for family members—the Community Reinforcement and Family Training Approach (CRAFT)—which aims to bring individuals refusing services into treatment.<sup>90</sup> More information about CRA is given in [Chapter 3](#).



## Components of Community Reinforcement Approach (CRA)

- 1. Functional Analysis of the Client's Substance Use:** Providers explore the perceived benefits and negative consequences of the client's substance use to identify how the target behavior is being reinforced and which new behaviors can be promoted to discourage alcohol and/or drug use.
- 2. Sobriety Sampling:** Providers encourage clients to move toward long-term abstinence by reaching agreement to test out a time-limited period of abstinence, developing a plan, and building tools to achieve the initial goal.
- 3. Treatment Plan:** Providers emphasize that all aspects of the client's life are important and identify areas of discontent. Together with the provider, clients identify areas to work on and establish goals for the treatment and specific methods to achieve them.
- 4. Behavioral Skills Training:** Through instruction and role-playing activities, providers build problem-solving, communication, and drug refusal skills with the clients so they can better navigate their substance use issues and work toward a healthier lifestyle.
- 5. Job Skills Training:** Providers help clients move toward obtaining and keeping a valued and rewarding job, which is considered one key source of reinforcement for a substance-free lifestyle.
- 6. Social and Recreational Counseling:** Providers help clients better understand how they can enjoy life without drugs and/or alcohol, by encouraging them to pursue new social and recreational activities. This counseling supports clients' recovery and helps them discover new purpose(s) in life.
- 7. Relapse Prevention:** Providers teach clients to identify high-risk situations and cope with recurrence of symptoms through specific skills and techniques that can help them prepare for challenges to their sobriety.
- 8. Relationship Counseling:** Provider aims to help clients improve interactions with their partners (or family members or other individuals close to them), building stronger relationships by developing communication and problem-solving skills.

**Source:** Meyers, R. J., Roizen, H. G., & Smith, J. E. (2011). The Community Reinforcement Approach: An update of the evidence. *Alcohol Research & Health*, 33(4), 380-388.

Previous research with the general population (i.e., including those not experiencing homelessness) determined CRA to be a treatment with a strong evidence base.<sup>91</sup> CRA appears to have positive effects on alcohol and other substance use outcomes.<sup>92,93</sup> It is associated with increased abstinence and retention at follow-up when combined with a contingency management approach, which involves providing rewards for positive behavior.<sup>94</sup>

Four studies that used CRA with individuals experiencing homelessness were included in this review. Three were RCTs comparing CRA to usual care or other treatment,<sup>80,95,96</sup> and a single large longitudinal study examined A-CRA through a non-randomized design to compare it to treatment-as-usual.<sup>97</sup>



## Outcomes Associated With CRA

Two studies demonstrated that use of CRA with unstably housed individuals was significantly associated with the following outcomes:

- Decreased reported alcohol and drug use at six months after treatment<sup>96</sup>
- Decreased symptoms of depression at six months after treatment<sup>96</sup>
- Decreased internalizing of problems, such as physical complaints, feelings of anxiety/depression, and feelings of withdrawal, at six months after treatment<sup>96</sup>
- Increased social stability, measured as the percent of days in work, education, being housed, and/or being seen for medical care, at six months after treatment<sup>96</sup>
- Decreased frequency of drug use in the 12 months after treatment<sup>95</sup>
- Both studies were conducted by the same research team (in different settings) and had relatively small sample sizes (<200 participants in comparisons used to detect effect differences).

Two other studies, both quantitative, found no significant positive effects of CRA.<sup>80,97</sup> In one, CRA was associated with decreases in substance use in the two years following treatment, but two other treatment models, MI and ecologically-based family therapy, were equally effective.<sup>80</sup> In the other study, CRA was associated with reduced frequency of substance use, but was inferior to the treatment that sites already provided.<sup>97</sup>

*\*This finding was statistically significant for the as-treated sample, but there were no significant differences among the intent-to-treat samples.*

## Typical Settings

CRA is often delivered through inpatient programs or via home visits. In the above studies, treatment settings included drop-in centers offering services to youth and young adults experiencing homelessness<sup>95,96</sup> and the family homes of participating youth who were considered homeless due to having run away.<sup>80</sup>

## Demographic Groups

CRA is used across genders, ages, races, ethnicities, and other demographic characteristics, in both individual and group settings. In each of the above four studies, CRA was delivered to youth or young adults between the ages of 12 and 25 experiencing homelessness.<sup>80,95-97</sup> In two studies, a majority of participants reported as African American,<sup>80,95</sup> while in the two other studies, participants predominantly identified as White.<sup>96,97</sup> Two studies reported on sexual/gender identity, in which 77 and 90 percent of participants reported as heterosexual.<sup>95,97</sup> In three studies, participants met DSM-IV criteria for alcohol or drug dependence or abuse.<sup>80,95,96</sup> One study found that participants reported using substances on a third of the days in the past three months<sup>80</sup>; another found reported substance use on approximately two-thirds of the days in the past 90 days.<sup>95</sup> Finally, one study reported that more than 75 percent of participants used drugs before the age of 15, with more than 80 percent testing positive for cannabis at baseline.<sup>96</sup>

## Provider Types

Healthcare professionals who possess fundamental counseling skills, such as supportiveness, empathy, and a caring attitude, can implement the CRA intervention. CRA requires therapists to be directive, energetic, and engaging. Official certification as a CRA provider requires a two-day training course, followed by review of 10 to 15 initial treatment sessions. In the reviewed studies, master's-level professional counselors<sup>80,95,96</sup> or graduate students trained in couples and family therapy<sup>80</sup> delivered CRA.

## Intensity and Duration of Treatment

It is recommended that CRA sessions take place on a weekly basis, and do not have a pre-defined number of sessions.<sup>98</sup> A-CRA has a typical duration of 10 sessions that last 60 minutes each,<sup>99</sup> including 4 sessions that involve the adolescent's caregiver(s).<sup>97</sup> In the studies reviewed, CRA lasted between 12<sup>95,96</sup> and 14 sessions.<sup>80</sup>

# Peer Support

## Overview

Peer support encompasses a range of activities and interactions between people who share similar experiences of being diagnosed with mental health disorders, SUDs, or both. Individuals with lived experience who provide peer support may be referred to as peer navigators, peer support workers, peer specialists, peer recovery coaches, peer recovery specialists, trained peers, peer supporters, or simply peers. In the context of this guide, peers are individuals who have successfully recovered from mental health disorders and/or SUDs and/or previously experienced homelessness. Peers assist clients entering or in recovery as they access behavioral health and other support services, including referrals to housing.<sup>100</sup> Peers can be especially valuable for individuals experiencing homelessness, who often have complex needs and navigate both behavioral health and social services systems.

Through their common experiences, successful peers can connect with clients in a non-judgmental way and encourage them to engage in treatment services.<sup>100</sup> Peers model recovery, promote shared understanding, focus on

strengths, offer positive coping strategies, and provide information and resources. They help steer individuals through complex health and social services systems and are often perceived by clients as possessing greater empathy because of their similar lived experiences.<sup>101</sup> Peers provide both practical support (e.g., accompanying clients to medical appointments, advocating for them, helping them access healthcare services and substance use treatments) and emotional support (e.g., empathy and reflective listening).<sup>101,102</sup> More information about implementation of peer support services is given in [Chapter 3](#).

Peer support among the general population (i.e., including those not experiencing homelessness) has been found to be associated with reduced substance use, increased treatment retention, and greater treatment satisfaction. However, because these studies are not true experiments,<sup>103</sup> and because peers are sometimes used to deliver other interventions (such as MI and intensive case management), it is challenging to discern the exact and independent effects of using peers on outcomes.

Two studies that use peers as navigators are included in this review: an RCT<sup>101</sup> that was conducted in the United States and a mixed-methods study<sup>102</sup> that was based in the United Kingdom.



## Outcomes Associated With Peers as Navigators

The two studies included in this review suggest that use of peers as navigators for unstably housed individuals was associated with the following outcomes:

- Increased engagement with healthcare, support services, and housing support<sup>102</sup>
- Reduced mental health concerns/psychological distress\*<sup>101,102</sup>
- Reduced anxiety\*<sup>102</sup>
- Decreased rates of injection drug use\*<sup>102</sup>
- Increased total resources, both internal and external, that a person has access to and can use to start and sustain recovery<sup>104,105</sup> and/or positive effects on recovery\*<sup>101,102</sup>
- Reduced homelessness\*<sup>101</sup>

Outcomes were assessed at the end of the intervention period (12 months).<sup>101,102</sup> In one of the two studies, while the majority of participants received the intervention for 12 months, some participants received a shortened intervention that lasted 2 to 2.5 months due to a peer navigator's early departure.<sup>102</sup>

*\*Study showed significant outcomes at follow-up.*

## Typical Settings

Peers can work in any setting. In the above two studies, clients were recruited through clinics and homeless shelters.<sup>101</sup> In one study, peers met face-to-face with clients in places and at times that were convenient to the client—there was no set intervention delivery setting.<sup>101</sup> In the other study, peers delivered services via outreach programs in Salvation Army hostels in Scotland and England.<sup>102</sup>

## Demographic Groups

Peers can be used with most populations to improve their access to and engagement with behavioral health services. In one of the studies included in the evidence review, peer navigation was delivered to individuals experiencing homelessness and substance use, with most participants reporting severe substance use that had a substantial impact on their daily lives.<sup>102</sup> Participants also reported mental health concerns at baseline, as

evidenced by assessment measures of mental health and depressive symptoms and self-reported suicidal or self-harm thoughts (78 percent of participants).<sup>102</sup> In the other study, peer navigation was delivered to African Americans who were experiencing homelessness and serious mental illness (SMI), including major depression, bipolar disorder, anxiety disorder, post-traumatic stress disorder, schizophrenia, and other disorders.<sup>101</sup>

## Provider Types

By definition, a peer is an individual who has similar lived experiences as their clients. Peer support programs may use peers formally or informally; formal use involves certified peers, whereas informal use may involve peers who do not have formal certifications or trainings.<sup>106</sup> Many states have peer specialist certification and credentialing programs.<sup>107</sup> In the two reviewed studies, peers had lived experiences of homelessness, as well as SUD<sup>102</sup> and/or SMI.<sup>101</sup> Neither program required peers to have official state or professional body certification.

In one of the two studies, peers had relevant prior experience working in a social care role, such as within residential rehabilitation and supported accommodation settings, and received regular supervision from a clinical psychologist throughout the intervention period.<sup>102</sup> Peers received training on relevant topics, such as harm reduction, [trauma-informed approaches](#), MI, negotiation of professional boundaries as peer workers, therapeutic relationships, and naloxone administration.<sup>102</sup>

## Intensity and Duration of Treatment

Peers tailor support to meet the needs of the client, so the intensity and duration of treatment can vary. In the two studies reviewed for this guide, peers worked with clients most commonly for one year.<sup>101,102</sup> In one study, the peers attempted to contact clients at least once a week; depending on the clients' needs, the frequency of attempted contacts could be as high as five times per week.<sup>101</sup>

## Other Evidence-Based Practices to Support Behavioral Health Needs

Housing First provides a long-term housing subsidy or other stable housing options and access to behavioral health and other services, regardless of an individual's behavioral health conditions. This systematic review excluded studies of Housing First, given that the focus of this guide is on support for individuals *before* they have been placed in stable housing. Studies have shown that Housing First contributes to reductions in alcohol use and increased outpatient visits, outpatient service utilization, and outreach to and engagement of clients.<sup>108-110</sup>

ACT is an important intervention for individuals with the most intensive needs, providing a full range of services to support individuals with SMI, and typically includes medication management, help finding housing, connection to local and/or federal benefit programs, and vocational or educational supports.<sup>111</sup> This guide did not include ACT, as it offers a higher level of service than most subjects of this guide may need. An ACT team is available to respond at any time, seven days a week. In these respects, ACT is the most intensive form of case management that an individual may access. Both Housing First and ACT can be offered in a variety of settings, prior to and after housing attainment. Both [evidence-based practices](#) may incorporate techniques discussed in this chapter, such as MI and peer support.

## Limitations of Research and Future Directions

This guide focuses on providing behavioral health support to individuals with behavioral health disorders who are experiencing homelessness and have not yet been placed into stable housing. Housing indeed plays a vital role in stabilizing mental health and helping individuals work toward recovery; however, studies focused on providing support to people experiencing homelessness prior to their moving into stable housing are limited in number and scope. None of the interventions in this chapter was designed or intended specifically for this period of homelessness; they all are models or approaches with wide applicability and

were adapted to fit the needs of individuals during this transition period and once stably housed.

Existing variations to these interventions include:

- Populations served
- Duration
- Who delivers them
- Who supervises those delivering them
- Settings in which they are implemented

Adaptations to the interventions identified in this review had different effects on key outcomes (e.g., long-term service engagement, effects on mental health and substance use outcomes). In addition, the studies included in this review are primarily observational in design; therefore, outcomes associated with these approaches should be interpreted with caution. More in-depth research is needed with individuals experiencing homelessness prior to being housed, especially with individuals who are most vulnerable to experiencing homelessness, such as those who identify as LGBTQI+. Further research can examine:

- What are the most pressing needs related to addressing mental health disorders and/or SUDs?
- What interventions or program components are most effective, for which specific populations, and in what settings?
- For LGBTQI+ populations in particular, how effective are the interventions identified in this chapter, and what other interventions may be important to consider?
- Which of these approaches offers the greatest flexibility, and which ones are best received by people experiencing homelessness?

Future research should highlight strategies used during homelessness, so that others in the field can replicate successful efforts to improve access to and use of behavioral health and other needed supports by people experiencing homelessness while they wait to be placed in housing. Qualitative research describing important contextual factors and implementation decisions during the program design and implementation phases would be valuable to supplement findings of existing quantitative outcomes research.

# Guidance for Selecting and Implementing Evidence-Based Interventions



## Overview

This chapter provides information for program administrators, providers, staff members, and community partners interested in implementing an intervention for individuals experiencing sheltered and unsheltered homelessness and who have mental health disorders and/or substance use disorders (SUDs). It discusses common implementation considerations and related strategies when engaging and treating this population and ensuring high quality care.

## Implementation Considerations and Strategies for Organizations

### Determine Service Gaps and Select an Intervention

**Consideration:** Agencies should tailor new services to the needs of the communities they serve, thus ensuring that individuals will access the service and making it more likely to be sustainable. However, given the complex needs of people experiencing homelessness and the service landscape, it can be difficult for providers and organizations to decide which services are needed most.

### Strategy:

- **Conduct a needs assessment and elicit feedback from individuals experiencing homelessness and relevant community organizations.** People with lived experience of homelessness can offer insight into the services that this population needs. Include other community organizations serving people experiencing homelessness, as they have a deep understanding of gaps in the service landscape.

If individuals in the community have an elevated level of need and service coordination is complex, intensive case management may be especially helpful.<sup>113</sup> If the population experiencing homelessness is reluctant to engage with providers, peers as a frontline strategy may be effective in engaging individuals to either provide intensive case management or work alongside other staff. A community-based participatory (CBP) approach to

**A community-based participatory approach** upholds the engagement and participation of those who the issue or problem at hand affects and recognizes and appreciates the unique strengths and resources each [stakeholder](#) contributes to the process. It is a cooperative, co-learning process that involves systems development and local community capacity-building.<sup>112</sup>

program planning can help organizations identify and address [health inequities](#) among socially disadvantaged and [under-resourced communities](#).<sup>114</sup> Using this approach, providers and organizations planning implementation engage trusted members of the community in needs assessment and program planning. These individuals make decisions with other partners, to ensure that the selected program will be of the utmost benefit.

## Engage Community Partners and Other Stakeholders

**Consideration:** The local [Continuum of Care](#) (CoC) is a planning body designed to provide funding for the efforts of nonprofit providers and state and local governments to

**Community partners and stakeholders** may include members of the local CoC, as well as other organizations or individuals with an interest in improving outcomes and facilitating recovery for individuals experiencing homelessness.

quickly rehouse homeless individuals and families.<sup>115</sup> When implementing a program, obtaining guidance and support from members of the CoC makes it more likely that a specific intervention or program has the resources needed to deliver sustainable services. In addition to the CoC members, an agency can work with non-CoC organizations serving this population, the implementing organization's leadership, and those experiencing homelessness themselves.

### Strategies:

- **Engage individuals experiencing homelessness.** If using a CBP approach, include individuals on the planning team with lived experience. These individuals are in a unique position to share information about the program with their peers and obtain others' input that may contribute to the planning process. Trusted community members and individuals with lived experience provide credibility to the program and enhance acceptance within the community.
- **Engage relevant community organizations.** Local CoC members and other relevant community organizations, such as SUD treatment programs, opioid treatment programs, harm reduction programs, shelters, housing providers, and members of the local CoC, as well as service

providers, are key partners in providing services to individuals experiencing homelessness. Involving community organizations in program planning is important for program success and ensures that clients have access to other needed services not available through the implementing organization.<sup>114</sup> Partnering with other organizations is particularly important for certain practices, such as intensive case management and peer support models, because integration and coordination of services is an integral part of the CoC model.

- **Engage organizational leadership.** Organizational decision-makers should be involved in the planning process from the beginning, to ensure they understand the need for and importance of the program. Including leadership in discussions about services for individuals experiencing homelessness will help ensure that the organizational culture, policies, and staff support the services. For organizations that are not explicitly focused on individuals experiencing homelessness, leadership can play a critical role in creating positive environments that serve this population.

Buy-in among organizational leadership also has practical implications for staff implementing the intervention, including providing dedicated times for staff training, hiring of new staff (e.g., peers), and program [sustainability](#).<sup>116</sup> Whenever possible, organizational leadership should seek to implement policies and operating procedures requiring the inclusion and engagement of experts with lived experience and ensuring equitable compensation for these individuals. Doing so further ingrains the importance of seeking input from those with lived experience into the organizational culture and helps services be better tailored.

## Secure Sustainable Funding Streams

**Consideration:** Sustainable programming is important for programs serving individuals with mental health disorders and/or SUDs experiencing homelessness because this group typically has few options for treatment that fits their multifaceted needs. When a program serving individuals experiencing homelessness shuts down, it can mean a disruption in services.



### Strategies:

- **Use data to support program effectiveness, impact, and sustainability.** Program data can show funders that programs are successful. Data can include positive behavioral health and housing outcomes, receipt of funding from new sources, cost savings, and the benefit of the organization’s partnerships to the organization and other programs. Each of these successes can be helpful in attracting continued or new funding. Providers and organizations should use lessons learned from ongoing efforts to show potential funders the rationale for any needed program modifications and how these adjustments will improve service delivery. The U.S. Department of Housing and Urban Development (HUD) offers [several considerations for program sustainability](#).
- **Diversify funding sources.** Sustainable organizations do not depend on only one source of funding. Multi- and single-year funding from a variety of funding sources, including the federal government, state government, foundations, and private donors, can show potential funders the value that existing investors see in the organization’s programs. Organizations may also seek Medicaid certification for their providers; while this process can be intensive, it can offer longer-term sustainability for a program.
- **Leverage community support.** Local support and enthusiasm for programming can show funders how valuable the organization’s services are, as well as potentially lead to support for and participation in fundraising events and activities. Organizations can seek community engagement during the program planning phase, not just when an organization needs support to sustain funding.

### Build and Support a Strong Workforce

**Consideration:** Individuals experiencing homelessness have often experienced trauma, have been under-served and stigmatized, and can be distrustful of healthcare institutions that have failed them in the past. Hiring and supporting appropriate staff is the basis for developing and implementing successful programs to serve this population.

### Strategies:

- **Hire a well-trained, diverse team.** Program staff are the core of any successful program. A diverse workforce that reflects the racial and ethnic compositions, languages, and lived experiences of the organization’s clients improves treatment initiation, delivery of culturally and linguistically appropriate treatment practices, treatment retention and adherence, and health outcomes.

- **Provide adequate time for training.** Program success depends on the ability of providers to implement the intervention effectively in the intended population. In addition to clinical training, administrators should provide adequate time for training on the complexities of the population, including current and historical barriers to care. More details about training are offered below.
- **Integrate peers into service provision.** Given the stigma individuals who are homeless often experience, they may trust peers more than clinicians or case managers, due to peers' shared experiences. As discussed in [Chapter 2](#), peer specialists optimize and promote recovery and increase trust.<sup>100</sup>
- **Staff retention.** All clients with mental health disorders and/or SUDs are likely to benefit most from continuity of care. Given the instability of their living circumstances, individuals experiencing homelessness may struggle to maintain their health with high turnover rates among service providers. Youth, especially, need stability, continuity, and commitment from support workers.<sup>117</sup>
- If staff turnover within the organization is an issue, program administrators should seek to understand and address the root causes. Strategies may include providing more training, guidance, and support if employees are not feeling supported professionally, or providing a better work-life balance if employees are experiencing burnout. If burnout is an issue, SAMHSA's guide on [addressing burnout in workplace settings](#) may be helpful.

## Provide Specialized Training

**Consideration:** Given the complex physical and behavioral health profiles of many individuals experiencing homelessness, providers must have skills such as the ability to be empathetic, build rapport, adopt a trauma-informed approach, and recognize their own biases. The quality of care that providers give will affect treatment adherence and retention among clients, so training is crucial.

### Strategies:

- **Provide training on delivery of trauma-informed approaches.** Trauma is prevalent among individuals experiencing homelessness.

## Trauma-Informed Approaches

Many people experience a traumatic event or live within traumatic circumstances or chronic trauma or stress. SAMHSA has identified [four principles that ground trauma-informed care](#).

1. People at all levels of the organization or system have a basic realization about trauma and understand how trauma can affect families, groups, organizations, and communities, as well as individuals.
2. People in the organization or system are able to recognize the signs of trauma.
3. The program, organization, or system responds by applying the principles of a trauma-informed approach to all areas of functioning.
4. A trauma-informed approach seeks to resist re-traumatization of clients and staff.

Reference: Substance Abuse and Mental Health Services Administration. (2014). [SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach](#).

Therefore, those interacting directly with clients, including front desk and other non-clinical staff, should train in delivery of trauma-informed approaches. Ensuring that clients always feel safe, welcome, and respected are the first steps to providing high-quality care.

- **Understand risk factors and barriers to care.** Understanding the common risk factors for homelessness, barriers to care, and common daily experiences among this population are important, not only for providing care that addresses these concerns, but also for providers to develop a sense of empathy for clients and make meaningful connections.
- **Explore and reduce stigma.** Prior to beginning work with individuals who are experiencing homelessness, staff members should be aware of their own biases and stigma and take steps to address them by undergoing implicit bias and cultural humility training. Stigmatizing or mistreating a client who may justifiably distrust institutions means that the client likely will not remain engaged in services.



## Reduce Barriers to Engaging in Treatment

**Consideration:** Providing services to individuals experiencing homelessness can be difficult due to the many barriers to care that this population faces; these barriers can negatively affect treatment initiation, adherence, and retention. Common barriers include:

- Transportation difficulties
- Conflicting appointments
- Lack of childcare
- Lack of personal identification or documentation
- Lack of health insurance and other resources
- Competing priorities, such as the need to find daily food, shelter, and safety

Providers should identify barriers to care that are specific to their clients' location and understand how the organization can address them to the extent possible, at the outset of program implementation.

## Strategies:

- **Provide co-located services in a convenient location and extend hours of operation.** The location of services should be convenient for those experiencing homelessness who have limited access to transportation and should be co-located with other services whenever possible. [Community Health Centers](#) work on this principle. Providers can consult with individuals experiencing homelessness to identify the ideal locations and hours of operation for services. If clinic-based, hours should be flexible and extended to minimize the possibility of conflicting appointments. Childcare services should also be made available, if possible, so parents/caregivers can receive care without needing to also find childcare.
- **Limit requirements to receive services and streamline intake procedures.** Individuals experiencing homelessness may not have standard forms of identification. Intake procedures also often take a substantial amount of time, which could further deter someone without childcare or who has competing priorities. Organizations should review their intake procedures, and, wherever possible, simplify or defer admission requirements and intake procedures until a later date if necessary.<sup>118</sup>
- **Use mobile services.** Mobile services enable providers to meet the client in a location that is most convenient and comfortable for them. When available, this is an ideal option to serve those experiencing multiple barriers, such as transportation, mobility issues, or childcare.<sup>118</sup> Mobile services may also be preferable for those who have experienced trauma, or who may face shame, stigma, and discrimination when seeking services. For individuals who are experiencing homelessness, this may mean providing services within shelters, in encampments, and other non-clinical settings.
- **Use assertive outreach to reach clients.** Assertive outreach enables providers to connect with people and offer information about services in a location where potential clients feel comfortable.<sup>119</sup> It also provides an opportunity to develop trusting relationships, and to quickly identify needs and provide access to services.

## Collect Data and Evaluate Effectiveness

**Consideration:** As noted above, it is important to collect and assess outcomes data when implementing a program or practice. If outcomes are positive, evaluation findings can be used to obtain further funding; if not, the data can provide useful information on necessary program and practice improvements. Staff members should regularly review and discuss these data with supervisors to ensure the practice is having intended effects.

### Strategy:

**Evaluate effectiveness and disseminate findings.** While data collection and evaluation can be complex and time-consuming, evaluating effectiveness and sharing these outcomes internally and with the field adds to the evidence base and helps program administrators, providers, and others understand what works and what does not. [Chapter 5](#) provides information on how organizations can incorporate evaluation into their program activities.

## Implementation Considerations and Strategies for Clinicians and Other Staff Members

### Implement Practices with Fidelity but Adapt as Needed

**Consideration:** In addition to being culturally, linguistically, and ethnically diverse, individuals experiencing homelessness may face complex co-occurring mental health disorders and SUDs, as well as other health issues. Additionally, programs serving these individuals are often working with resource constraints, including staff and space to deliver treatment services and time to see clients. These factors can make adaptation of a program necessary. When adaptation occurs, it is still important to maintain [fidelity](#) to the program's core components to ensure optimal outcomes for clients.

### The Role of Outreach

[Outreach](#) plays a critical role in identifying people experiencing homelessness and promoting engagement with supportive services. In a 2019 brief,<sup>120</sup> the U.S. Interagency Council on Homelessness named the following core tenets of effective street outreach:

- 1. Systematic, Coordinated, and Comprehensive.** Outreach is most effective when coordinated among multiple stakeholders and partner agencies, allowing for more comprehensive coverage. Connecting outreach efforts to coordinated entry processes can help ensure people are documented in the Homeless Management Information System. Establishing data-sharing agreements and protocols can ensure people are served as effectively and efficiently as possible across providers.
- 2. Housing-Focused.** To the extent possible, outreach efforts should use Housing First approaches, which do not require abstinence from substance use as a prerequisite for housing. The goal of street outreach is to make connections so that people can be supported as they seek stable housing. Street outreach should offer immediate connections to emergency shelter or temporary housing when possible and to behavioral health services.
- 3. Person-Centered, Trauma-Informed, and Culturally Responsive.** Outreach efforts should never make assumptions about what someone needs or wants; rather, outreach should involve multiple offers of assistance while also giving people the opportunity to say "no." Ideally, outreach should include staff with lived experience. Efforts should always be respectful and responsive to the beliefs and practices of all persons, and it is best practice for staff to be trained in issues of equity and cultural and linguistic competency.
- 4. Emphasizing Safety and Reducing Harm.** Outreach efforts should be managed according to protocols that ensure the safety of all people and prioritize safe and confidential access to the coordinated entry process. As appropriate, services should consider using harm reduction principles and accept that not everyone will be receptive to offers of assistance. Outreach plays a key role in building rapport, creating connections to services, and especially providing critical, life-saving resources, such as clean water, food, clothing, blankets, and other necessities.

## Strategies:

- **Carefully balance adaptation with fidelity of practice.** Fidelity, also referred to as adherence, is the extent to which the staff member delivering an intervention adheres to the core components of the protocol or practice model. Fidelity is critical to obtaining intended program outcomes. In general, removing program components can be detrimental to fidelity, but adapting components to address local conditions may improve program or treatment practice outcomes, including when they fill an important need among clients. In general, it is important for those implementing programs to understand if findings on their effectiveness extend to the population served. The greater the similarity between research participants and the people that the practice serves, the more generalizable the outcomes will be. SAMHSA's guide on [adapting evidence-based practices for under-resourced populations](#) provides more information on adapting evidence-based practices.
- **Adapt treatment practices to the client's culture, values, and preferences.** Treatment practices have often been designed for and evaluated with a predominantly White population, and adaptation may be necessary when delivering the program to individuals from other groups, such as racial and ethnic minorities, individuals who identify as LGBTQ+, older adults, and persons with physical or cognitive disabilities.<sup>121</sup> If relevant, staff members should adapt the treatment to make it more appropriate for the client. Motivational interviewing (MI) techniques, for example, are adaptable to multiple cultures, as the process of change and motivational enhancement can be tailored to the values, beliefs, and experiences of individuals from different ethnic, cultural, and racial backgrounds.
- If a staff member is not knowledgeable about a client's culture, they should be willing to learn more to better serve the client. Acknowledging what staff do *not* know about a client's background and being honest with clients can go a long way in developing rapport, by showing the individual that the provider cares and is interested in learning about their experiences and viewpoints. This willingness to learn is valuable

when developing a relationship with all clients, and especially so with individuals who have had previous negative experiences with service agencies.

- **Consider combining multiple behavioral health interventions and other social supports.** For individuals with co-occurring disorders, complex trauma histories, and high need for social services, it is likely that one approach to treatment will not address all the clients' needs. Clinicians and other direct care providers should collaborate with the client and community partners to provide needed social supports, such as assistance with housing and other necessities.

## Engage and Retain Clients in Care

**Consideration:** Individuals experiencing homelessness often have low rates of treatment initiation, retention, and completion. It can be difficult to keep clients engaged in care for many reasons. Clients' competing needs, as discussed earlier, may also take precedence. Substance use, illness, poor physical health, cognitive impairment, or mental illness may also affect engagement.

If a client is having difficulty making appointments or engaging in treatment, providers should seek to understand why, address the issue with the client, and engage in problem-solving to retain them in care.

## Strategies:

- **Assess and address clients' barriers to care.** Providers should be aware of and help overcome barriers their clients are facing, whether by helping them obtain a bus pass, identification, or proof of insurance, or submitting paperwork to Medicaid or a housing authority.<sup>116</sup> If substance use or a medical problem is affecting engagement in care, staff members should provide a referral to treatment that is easily accessible and convenient for the client. Staff can also use MI to influence the uptake of the recommendation, as noted below and described in [Chapter 2](#).
- **Build trust with the client.** The process of establishing trust and rapport with a client can take considerable time but can have a substantial impact on treatment engagement and retention. Words alone will often not be enough to elicit trust; it is important to follow through with

actions.<sup>116</sup> For example, early in the relationship, case managers may want to identify and work on “easy wins,” to begin to elicit trust and show clients that follow-through can be expected.

- ***Sequence practices and interventions to align with client readiness.*** Providers can gauge client readiness for services and apply the practices and interventions identified in [Chapter 2](#) in a sequence that fits best with client needs. For example, some clients may be most receptive to a harm reduction approach and use of MOUD but may not be interested in other support. Other clients may be open to interactions with a peer support specialist but may not be ready for intensive case management. Homelessness, especially chronic homelessness, can lead to a feeling of helplessness, for which MI can be particularly helpful.<sup>122</sup> If a client is receptive, providers can use MI to engage clients in treatment alone or in conjunction with other approaches, to enhance retention and adherence throughout the treatment process.<sup>72</sup> A Community Reinforcement Approach requires considerably more buy-in from clients than some of the other strategies, so a client may need some time until they are ready to engage in that level of structured intervention.
- ***Engage clients in treatment decision-making.*** Often, individuals experiencing homelessness feel a lack of control or autonomy over their situation. One way to facilitate engagement in treatment is to ensure the client has a role in selecting the treatment modality and deciding what they would like their goals and outcomes of treatment to be. Person-centered care, including shared decision-making, has been associated with improved mental health outcomes.<sup>123,124</sup>

## Integrate and Coordinate Services

**Consideration:** Given their complex and multifaceted needs, those experiencing homelessness may receive services from several providers for different medical and behavioral health-related issues. If these services are not already centrally provided, providers should coordinate treatment plans to work together toward shared goals.

### Strategies:

- ***Ensure communication and collaboration among a client’s providers.*** The optimal setting for clients with complex needs, such as those experiencing homelessness, is one that integrates

physical health, mental health, and substance use treatment services in one location, with multidisciplinary treatment teams that can work together toward shared client goals. Health Care for the Homeless models, [Community Mental Health Centers](#), and federally qualified health centers (FQHCs) are examples of providers that use multidisciplinary treatment teams.<sup>125-127</sup> However, these models are not available everywhere. Where integrated services are not possible, providers should examine their client’s other health and health-related social and economic needs, the extent to which these needs are being met, and how these needs play into their treatment. Organizations should obtain consent from clients to coordinate care across providers to work with clients on their unmet needs. The SAMHSA-funded Center of Excellence–National Council for Mental Well-Being maintains a [library of resources on behavioral health integration](#).

- ***Confirm data sharing ability across agencies.*** Data sharing across health departments and housing agencies is essential for the successful and coordinated care of individuals experiencing homelessness who have mental health disorders and/or SUDs. Data use agreements and/or memoranda of understanding are necessary for successful data sharing between agencies. The National Academy for State Health Policy has [a guide](#) to help facilitate data sharing among state agencies.
- ***Adapt care throughout client interactions.*** Behavioral health providers should determine how to adapt care throughout client interactions to ensure continuity, as client needs may change or evolve. The National Health Care for the Homeless Council offers a [curriculum for training staff on core competencies](#) to help ensure that providers deliver high-quality care that benefits clients and makes them want to remain engaged in their treatment and recovery. These core competencies include an overview of mental health disorders and/or SUDs, [Health Care for the Homeless](#) models, trauma-informed care, care coordination, MI, and more.

# Implementation Resources

## Medication for Opioid Use Disorder

- The Health Care for the Homeless Clinicians' Network gives [Recommendations for the Care of Homeless Patients With Opioid Use Disorders](#) to healthcare professionals providing health and behavioral health services to individuals experiencing homelessness who have opioid use disorder.
- The Kaiser Family Foundation's Issue Brief on [Addressing the Opioid Crisis: Medication-Assisted Treatment at Health Care for the Homeless Programs](#) presents findings from an analysis of health center data on the provision of medications for opioid use disorder, as well as interviews with providers and administrators from Health Care for the Homeless programs about strategies they adopted to implement medication-assisted treatment (MAT) programs.
- American Society of Addiction Medicine (ASAM) developed a one-hour on-demand training session, [Ensuring Access to MAT for People Experiencing Homelessness](#), that addresses Boston's Health Care for the Homeless Program. The training reviews the theory and practice of low-barrier, harm-reduction-oriented care for this population, helps participants consider programs and program policies to help people experiencing homelessness, and discusses where larger changes in policy are needed.
- The SAMHSA-funded Addiction Technology Transfer Center (ATTC) training on [Integrated MAT for Patients Experiencing Homelessness](#) explains best practices for providing MAT to people experiencing homelessness, including specific strategies that can enhance treatment in settings where doing so is not the primary mission of the organization.
- SAMHSA's Homeless and Housing Resource Center (HHRC) toolkit on [Whole-Person Care for People Experiencing Homelessness and Opioid Use Disorder](#) covers best practices for referrals and warm handoffs, as well as assistance in meeting basic needs, such as income, food, and mainstream benefits.

- The SAMHSA-funded [Opioid Response Network](#) allows providers to connect with a mentor who can provide additional education and training resources around MOUD. The network has local consultants in all 50 states and nine territories to respond to local needs by providing free educational resources and training.

## Motivational Interviewing

- Miller and Rollnick's [Motivational Interviewing: Helping People Change \(3<sup>rd</sup> Edition\)](#) is a starting point for information about MI.
- SAMHSA's advisory on [Using Motivational Interviewing in Substance Use Disorder Treatment](#) provides an overview of MI and discusses how providers can effectively use MI practices to engage clients in SUD treatment.
- SAMHSA's [Spotlight on Projects for Assistance in Transition from Homelessness \(PATH\) Practices and Programs: Motivational Interviewing](#) provides techniques for utilizing MI with individuals experiencing homelessness.
- SAMHSA's updated [TIP 35: Enhancing Motivation for Change in Substance Use Disorder Treatment](#) provides evidence for motivation-enhancement approaches (including MI) and guidance on how providers can use such approaches to increase client participation and retention.
- [Motivational Interviewing Network of Trainers](#) is an international organization dedicated to promoting MI implementation and training. Its website includes several background resources that may help organizations identify training events.
- The SAMHSA ATTC Network's [Talking to Change: An MI Podcast. Episode 39: MI With People Who Are Homeless](#) explores the use of MI with individuals experiencing homelessness.
- [Screening, Brief Intervention, and Referral to Treatment \(SBIRT\)](#) is an approach to the delivery of early intervention and treatment to people with SUD and those at risk of developing these disorders. It involves quickly assessing the severity of an individual's substance use, providing MI to increase insight and awareness of substance use, and assessing motivation to seek treatment. Finally, it includes a referral for those identified as needing more extensive treatment.

## Intensive Case Management

- British Columbia Ministry of Health’s [Intensive Case Management and Team Model of Care: Standards and Guidelines](#) provides standards and guidelines of care for implementing intensive case management, including engagement and street outreach, access and referrals, screening for eligibility, conducting assessments, developing a care plan, and provision and coordination of services.
- SAMHSA’s [TIP 27: Comprehensive Case Management for Substance Abuse Treatment](#) provides an overview of case management models, issues, and treatment considerations for clients with SUDs.
- Strengthening At-Risk and Homeless Young Mothers and Children’s [Step by Step: A Comprehensive Approach to Case Management](#) outlines four key steps in implementing a case management model, such as intensive case management.
- Employment and Social Development Canada’s [Toolkit for Intensive Case Management in Canada](#) assists organizations in implementing and maintaining intensive case management programs.
- One of SAMHSA’s Services in Supportive Housing (SSH) grantees is featured in the case study, [Services in Supportive Housing: The Impact of Intensive Case Management](#).
- Utah’s Division of Substance Abuse and Mental Health developed guidelines in their [Training Manual for Case Management Certification](#) to help familiarize providers with the case management process and potential challenges.

## Community Reinforcement Approach (CRA)

- Dr. Meyers is one of the developers of CRA. His website, [Robert J. Meyers, Ph.D. and Associates](#), offers background information on CRA, Adolescent-CRA (A-CRA), and CRA for Family Training (CRAFT). His organization offers training in all three models. Training in these models may be available from other sources as well.

- The Behavioral Health Recovery Management project developed [The Community Reinforcement Approach Implementation Manual](#), which includes clinical guidelines for intervention delivery, FAQs, and links to additional resources and recommended readings.
- [Chestnut Health Systems EBTx Center](#) offers training and certification for CRA and A-CRA.
- The American Psychological Association’s (APA) article on the [implementation of the Community Reinforcement Approach \(CRA\) in a long-standing addictions outpatient clinic](#) documents the process of utilizing a change management model to implement and sustain a CRA program.

## Peer Support

- SAMHSA’s Bring Recovery Supports to Scale Technical Assistance Center Strategy’s (BRSS TACS) [Peer Worker Overview](#) initiative provides an overview of peers and how services can be enriched by including those with lived experience in recovery.
- [SAMHSA’s Peer Support Advisory](#) describes models of peer support with particular focus on peers working in crisis service care settings.
- The European Federation of National Organizations Working With the Homeless developed the [Peer Support: A Tool for Recovery in Homelessness Services](#) policy paper, which describes barriers, facilitators, and recommendations for using peers.
- The City of Philadelphia’s Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) developed an interactive [Peer Support Toolkit](#) that describes organizational considerations for developing a peer support program and provides resources for integrating peers into the organizational workforce.
- The National Health Care for the Homeless Coalition (NHCHC) published a newsletter on [Speaking From Experience: The Power of Peer Specialists](#), which provides an overview of the power of peer specialists in supporting individuals seeking recovery from mental health disorders and/or SUDs. It also highlights the Mental Health Association of Southeastern Pennsylvania’s (MHASP) mobile peer support teams.

- The Behavioral Health & Wellness Program at University of Colorado Anschutz Medical Campus School of Medicine developed the [DIMENSIONS: Peer Support Program Toolkit](#), which provides instruction on how to create a successful and sustainable peer support program.
- The Transitions Research and Training Center at the University of Massachusetts Medical School developed the [Effectively Employing Youth Adult Peer Providers: A Toolkit](#) for provider organizations that employ or want to employ young adult peer providers.

## Behavioral Health and Homelessness

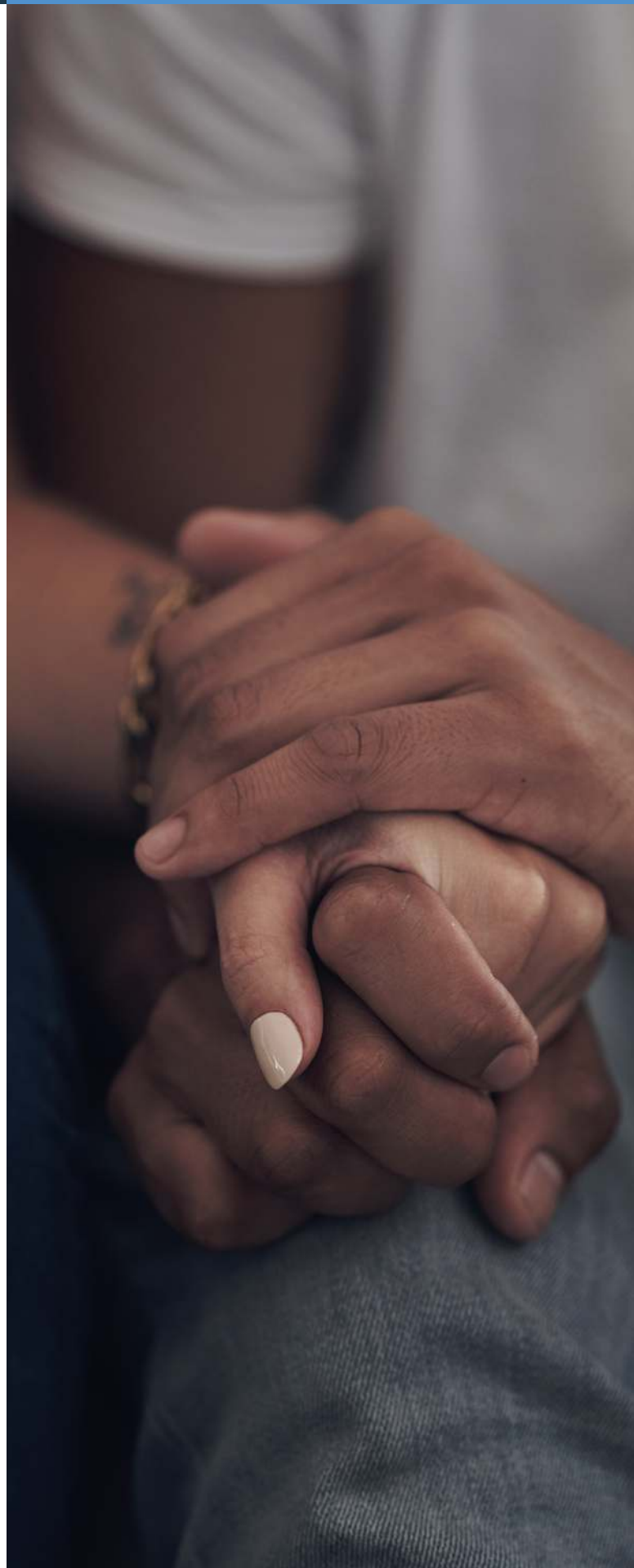
- The [Homeless and Housing Resource Center \(HHRC\)](#) provides training on housing and treatment models focused on adults, children, and families who are experiencing or at risk of homelessness and have serious mental illness and/or serious emotional disturbance, SUDs, and/or co-occurring disorders.
- SAMHSA's Advisory, [Behavioral Health Services for People Who Are Homeless](#), addresses the fundamentals of how providers and administrators can employ approaches to address the complex challenges of providing integrated treatment services to clients experiencing homelessness.
- The National Child Traumatic Stress Network (NCTSN) offers a [fact sheet on trauma and homeless children](#) to guide shelter staff in offering support to children and families who are experiencing homelessness and who have experienced trauma.
- Homeless and at-risk youth may be eligible for healthcare coverage under the Affordable Care Act (ACA), which can in turn help connect young people with supports to address their healthcare needs. This [fact sheet on health coverage for Homeless and At-Risk Youth](#) from the U.S. Department of Health and Human Services (HHS) describes eligibility, what services are covered, and how to sign up.
- The Health Care for the Homeless Clinicians' Network provides [Integrating Primary and Behavioral Health Care for Homeless People](#), exploring a variety of approaches to integrate primary and behavioral health care, listing common barriers faced and lessons learned.
- The National Health Care for the Homeless Council (NHCHC) has compiled several resources on [providing outreach to those experiencing homelessness](#). Topics include promising strategies for engagement, maintaining safety, and building bridges to services for those who are highly vulnerable, among others.
- The Canadian Observatory on Homelessness developed a book detailing practical strategies that service providers can take to address mental health and substance use among youth experiencing homelessness. This comprehensive resource, [Mental Health and Addiction Interventions for Youth Experiencing Homelessness: Practical Strategies for Front-Line Providers](#) covers topics that service providers inquire about most often.
- The article [Integrating Behavioral Health Services for Homeless Mothers and Children in Primary Care](#) describes a trauma-informed care management model integrating mental health, substance use, and support services for families experiencing homelessness in primary care.
- The issue brief on [Runaway and Homeless Youth, Mental Health, and Trauma-Informed Care](#), developed by the National Clearinghouse on Homeless Youth and Families, spotlights how to provide trauma-informed care to this population.

## Examples of Organizations Implementing Evidence-Based Interventions

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This chapter highlights four examples of organizations that have implemented interventions to address mental health disorders and/or substance use disorders (SUDs) among individuals experiencing homelessness prior to receiving stable housing.

- [City of Philadelphia Office of Homeless Services \(OHS\) / Resources for Human Development \(RHD\)](#). OHS contracts with RHD to provide a [strengths-based](#) intensive case management model, FaSST/Connections, to individuals and families living in shelters in Philadelphia.
  - RHD embeds one or more case managers into the shelters to identify individuals or families that have a significant mental health disorder and/or SUD.
  - Case managers provide linkages to mental health care, drug and alcohol treatment, housing referrals, and legal services.
- [Colorado Coalition for the Homeless \(CCH\)](#). CCH provides culturally specific behavioral health and related support through intensive case management, motivational interviewing, and use of peers to American Indian/Alaska Native (AI/AN) individuals experiencing homelessness.
  - Within Native-inclusive outdoor tent settings, CCH provides intensive case management services and Talking Circles for physical health, behavioral health, and cultural services.



- CCH operates a 250-bed, peer-led residential recovery community in rural Colorado that incorporates indigenous approaches to healing.
- **Horizon Behavioral Health.** Horizon Behavioral Health used the Adolescent Community Reinforcement Approach (A-CRA), along with wraparound services, for youth experiencing homelessness—supported through a SAMHSA grant.
  - The program starts with therapists building rapport with youth and identifying their goals for treatment, which then guide treatment and services throughout the program.
  - Horizon Behavioral Health leveraged community resources to connect youth experiencing homelessness to services beyond the completion of the grant.
- **Park Center.** Park Center, a behavioral health agency, integrates peer specialists, who have experienced homelessness and/or a mental health disorder or SUD, across all aspects of their agency services.
  - Peers help normalize conversations about experiencing mental health disorders, SUDs, and homelessness among the organization and its members.
  - Multiple peer specialists work on the Homeless Outreach Services team to provide physical, behavioral, and other supportive services through street outreach.

These case examples highlight various entry points for program implementation for people experiencing homelessness, as well as key themes:

- **Collaboration.** Collaborative partnerships are an important aspect of serving this population. Partnering with other organizations can extend the length and amount of time services are provided, the populations that can be served, and the nature and variety of interventions and services.
- **Wraparound services.** Services provided to those who have mental health disorders and/or SUDs should include medical, financial, housing, and cultural services and supports, in addition to mental health and substance use treatment. A Housing First philosophy is central for three of the four organizations featured in this chapter.
- **Accessibility.** Providers are most successful when they meet clients where they are, both in terms of taking a harm reduction philosophy and physically going to shelters and encampments. Access to services can be a barrier for many people experiencing homelessness, so focusing on how services can be provided in a variety of locations or where individuals sleep can increase engagement.



## City of Philadelphia Office of Homeless Services / Resources for Human Development – Intensive Case Management

Philadelphia, Pennsylvania

### Program

The Philadelphia Office of Homeless Services (OHS) works with more than 60 homeless housing and service providers and collaborates with the [Department of Behavioral Health and Intellectual disAbility Services](#) (DBHIDS) and the [Department of Public Health](#) to make up Philadelphia's homeless services system. Through this network, the city aims to make homelessness rare, brief, and nonrecurring. One of the many organizations contracted to provide services is [Resources for Human Development \(RHD\)](#). RHD is a national human services nonprofit headquartered in Philadelphia and provides an array of services, including behavioral health.

### Challenge

Philadelphia is often lauded for having the lowest number of people who are unsheltered per capita among all major U.S. cities.<sup>128</sup> Still, with a population of nearly 1.6 million, [point-in-time data](#) from 2021 found that 4,302 individuals were experiencing homelessness. Approximately 84 percent of these individuals reside in emergency shelters, safe havens, or transitional housing projects, and an estimated 20 percent of individuals experiencing homelessness in Philadelphia have a serious mental illness (SMI) or SUD.

### Intervention

The City of Philadelphia addresses mental health disorders and/or SUDs among its sheltered population through a contract with RHD, using a strengths-based **intensive case management** (ICM) model. RHD's program, called [FaSST/Connections](#), is a behavioral health case management unit that provides evaluation for, linkage to, and coordination of services to individuals and families living in shelters throughout the city. The program currently operates over 800 beds in 17 shelters and 2 safe haven facilities, which are settings that accommodate individuals with more significant and chronic mental illnesses and SUDs. Like many programs in Philadelphia, RHD Supportive Housing programs draw from a Housing First model.

### Implementation

FaSST/Connections is Medicaid-funded through a fee-for-service model, with additional funding through the managed care organization Community Behavioral Health. To be eligible for participation in FaSST/Connections, an individual must have a significant mental illness, be 18 years or older, cannot be receiving any other case management services, and must agree to receive services. The FaSST/Connections team includes 26 staff with a minimum of a bachelor's degree who have received Philadelphia's case management services training. FaSST/Connections has a psychiatrist on the team who helps facilitate connections to outside providers for medication management and more intensive mental health services, including therapy.

RHD embeds one or more case managers into each of the facilities in which it operates, an aspect of the program that is central to its effectiveness. Case managers work at the same shelter and with the same staff over time. By having a consistent and visible presence in the shelter, the case manager's presence is less intrusive, and many times, case managers can work with residents within the shelter itself. For each resident, the case manager creates a personal goal plan and then documents ongoing activities toward reaching the resident's goals. Specific case management services include linkages to mental health care, drug and alcohol treatment, housing referrals, and legal services. For individuals with substance use, DBHIDS offers **medication for opioid use disorder (MOUD)** through coordination with local organizations and shares a [list of service providers](#) who provide MOUD in Philadelphia to clients. Case managers also work to re-engage individuals with their natural support systems, such as families of origin and faith-based communities.

## City of Philadelphia Office of Homeless Services / Resources for Human Development – Intensive Case Management

### Philadelphia, Pennsylvania

In addition to embedded staff, a second key component of the program is its flexibility to provide services across settings and time. Support can be mobile; case managers can accompany a resident to medical or psychiatric appointments and other locations and can help residents navigate the community to better understand what supports they need. Case managers are careful to focus on support that empowers residents, rather than doing “for” them. Through the FaSST/Connections program, case managers can continue to provide support well after the time that the resident accesses stable housing. Intensive case management services can then ensure that the individual is stable and reduce the likelihood of returning to homelessness, address underlying reasons that led to their homelessness, and continue to connect them to services. Services may be provided for up to two years.

### Outcomes and Other Benefits

In 2021, RHD worked with approximately 580 sheltered individuals through the FaSST/Connections program. Given the highly transient nature of the population, it is not feasible for RHD to collect extensive data on the population receiving FaSST/Connections ICM services, and the program does not typically conduct clinical assessments. Case managers periodically monitor personal goal plans to assess ongoing needs, as well as areas where participants have successfully achieved their goals and are no longer in need of services.

### Lessons Learned

- **Use a strengths-based approach to intensive case management.** Providing intensive case management services that incorporate a strengths-based focus allows case managers to connect with individuals in an authentic and holistic way.
- **Embed intensive case management staff in the shelters to facilitate identification of needs.** Embedding staff into the shelters creates strong working relationships with shelter staff and leads to more efficient identification of residents in need of service.
- **Integrate intensive case management staff to enhance shelter staff knowledge.** Having case managers onsite helps educate shelter staff on how to better address challenging situations among residents, particularly those that may stem from underlying mental health conditions.

### Related Resources

[City of Philadelphia Office of Homeless Services](#)

[Resources for Human Development](#)

[FaSST/Connections description](#)



## Colorado Coalition for the Homeless – Services for American Indians and Alaska Natives

Denver, Colorado

### Program

Colorado Coalition for the Homeless (CCH) is a nonprofit organization established in 1985 that provides housing, health care, and supportive services to individuals experiencing homelessness in Colorado, including to American Indian and Alaska Native (AI/AN) individuals and families. Drawing from a Housing First approach, in 2020, CCH provided housing, health care, employment, and other services to over 22,700 people, with approximately 708 people identifying as AI/AN. CCH is a federally qualified health center (FQHC) with four satellite locations that provide comprehensive and integrated healthcare services.

### Challenge

While approximately 2 percent of Colorado's population identifies as AI/AN, they make up 6 percent of the state's homeless population, based on the 2021 Point-In-Time survey. Like many people experiencing homelessness, AI/AN individuals may experience anxiety, depression, PTSD, schizophrenia, and substance use, and often have significant medical comorbidities. In addition, AI/AN individuals often experience intergenerational trauma, cultural dislocation, and systemic racism.<sup>129</sup>

### Intervention

To provide culture-specific behavioral health and related support to AI/AN individuals experiencing homelessness, CCH administers programs through the organization's Native American Services branch and collaborates with other AI/AN-serving organizations. In Denver, the Colorado Village Collaborative helped establish Native-inclusive [Safe Outdoor Spaces \(SOS\)](#), with 30 to 60 tent accommodations.

CCH supports SOS with **intensive case management services** through a mobile medical outreach van, and provides mental health support, medical services, addiction support, psychiatry, and nursing. CCH identifies **motivational interviewing** as one of their core approaches to service delivery. Native American Services at CCH began facilitating "[Talking Circles](#)" and inclusive culturally celebratory programming in 2003. Talking Circles, which are a Native-focused healing space to facilitate sobriety, increase connections to Native culture, provide resources, and promote healing from physical and behavioral health concerns.

In collaboration with Bent County and more than 10 community partners, including the state of Colorado, CCH operates the Fort Lyon Supportive Residential Community. Fort Lyon is a **peer-led recovery setting** that provides recovery-oriented transitional housing for up to 250 individuals experiencing homelessness. Twelve percent of Fort Lyon's population are AI/AN residents. The program includes AI/AN peer supports and incorporates indigenous approaches to healing, among other services.<sup>130</sup> Fort Lyon includes the indigenous recovery model called [Wellbriety](#) where AI/AN people can "Walk the Red Road to Recovery." Wellbriety uses culturally based principles, values, and teachings to promote healing from alcohol, substance use, co-occurring disorders, and intergenerational trauma.

### Implementation

All of CCH's programming for individuals experiencing homelessness, including the Native American Services branch, relies on strong partnerships with local community organizations, city government, and state and federal agencies. CCH works closely with other AI/AN service, cultural, healthcare, child welfare, and advocacy organizations in the Denver metro area, and is a member of the Native American Housing Circle, a community coalition of Native-led and Native-serving community organizations that works to create affordable housing opportunities and direct services for Native American people experiencing homelessness and housing instability in the Denver metro area.

Another important facet of CCH services is the emphasis on integrated health care, which is available at all CCH clinic locations. CCH incorporates a harm reduction model to substance use recovery and offers **MOUD** at the Stout Street Health Center, five days a week.

## Colorado Coalition for the Homeless – Services for American Indians and Alaska Natives Denver, Colorado

### Outcomes and Other Benefits

As an FQHC, CCH collects process and outcome metrics for the Health Resources and Services Administration. In 2021, CCH reviewed the prior year's data by race and ethnicity and noticed disparities in outcomes related to depression screening and follow-up. In particular, the AI/AN clients they screened for depression received follow-up at a lower rate than other groups. Recognizing this disparity, CCH conducted focus groups to hear AI/AN client stories and experiences with accessing and receiving services. CCH is currently generating ideas for how to improve service provision for this population, based on input from AI/AN clients.

### Lessons Learned

- **Meet clients where they are, both mentally and physically.** CCH adheres to a harm reduction, trauma-informed philosophy and emphasizes flexibility in scheduling. If clients do not feel comfortable coming into a clinic, staff provide mental health and substance use treatment services in the community, in encampments, and other locations.
- **Be aware of cultural needs in working with AI/AN populations.** The AI/AN-specific interventions (such as Wellbriety and Talking Circles) are well-received because they integrate Native traditions and culture while still addressing the need for support with SUD and mental illness.
- **Community-based programming and individualized services and care can co-exist fruitfully.** Indigenous values, traditions, and beliefs place a different emphasis on community obligations, relationships, and reciprocity. Native American Services honors and makes a virtue of weaving communal traditions and knowledge with Western healthcare and housing system approaches.

### Related Resources

[Colorado Coalition for the Homeless](#)

[Colorado Village Collaborative's Safe Outdoor Spaces](#)

[Four Winds American Indian Council](#)

[White Bison Wellbriety](#)

[Denver Indian Family Resource Center](#)

[Denver Indian Health and Family Services](#)

[Denver Indian Center, Inc.](#)

[Native American Housing Circle](#)



## Horizon Behavioral Health – Adolescent Community Reinforcement Approach Cities of Lynchburg and Amherst, and Appomattox, Bedford, and Campbell Counties, Virginia

### Program

Horizon Behavioral Health is a Community Service Board in Central Virginia that has provided mental health, SUD, and intellectual disability services for over 50 years. Horizon Behavioral Health is a member of the Central Virginia Continuum of Care, which operates the homeless response system within Lynchburg and whose projects follow a Housing First approach. In 2017, Horizon Behavioral Health received a three-year federal grant through SAMHSA's [Cooperative Agreements to Benefit Homeless Individuals \(CABHI\)](#) to implement wraparound services for youth and young adults experiencing homelessness. As part of this approach, Horizon Behavioral Health used the Community Reinforcement Approach (CRA), alongside other services.

### Challenge

Between 2017 and 2018, rates of youth homelessness in Central Virginia increased by 50 percent, spurring Horizon Behavioral Health to develop additional services.<sup>131</sup> More than three-quarters of the youth experiencing homelessness served by Horizon Behavioral Health reported experiencing serious depression, and more than 85 percent reported serious anxiety or tension. In addition, more than one-third of the youth reported marijuana use in the month prior to intake.<sup>131</sup> The high rate of youth homelessness, along with high need for mental health and substance use supports, suggested the necessity for an intervention to improve behavioral health among this population.

### Intervention

Horizon Behavioral Health implemented the **Adolescent Community Reinforcement Approach (A-CRA)** within the context of their CABHI program in 2017, which included a variety of wraparound services intended to support youth experiencing homelessness as comprehensively as possible. Individuals referred to the CABHI program had an assigned case manager. The case managers monitored, assessed, and connected them to resources that could help meet their needs (e.g., food pantries, medical care, advocacy resources). A housing specialist helped identify short-term housing options (such as shelter placements) while also working with youth to identify stable housing goals. The program also used peer specialists, who were often primary points of contact for youth and key partners in promoting engagement with services.

### Implementation

In implementing A-CRA, Horizon Behavioral Health therapists initially worked to build engagement and rapport with the youth and follow their lead in identifying concrete goals for treatment and beyond. Therapists used assessments to facilitate dialogue about the youth's strengths, the positive and negative consequences of their substance use or other problematic behaviors, and how their lives could look different as they build reinforcers for more positive behaviors. Throughout treatment, A-CRA emphasized the role that social connectedness can play in reinforcing positive lifestyle changes. At the same time, Horizon Behavioral Health's A-CRA therapists focused on teaching skills to help youth achieve their goals, including broad skills like communication and problem-solving approaches, as well as more specific skills like job-seeking or interviewing techniques.

[Chestnut Health Systems](#) was a key partner in implementing A-CRA. Chestnut Health Systems provided the initial, 16-hour training to therapists (offered both online and in-person) and worked on [continuous quality improvement](#) and fidelity assessments, to ensure consistent, quality delivery of the model.

Horizon Behavioral Health also offers an **MOUD** program called Office-Based Addiction Treatment, which is designed to be integrated with psychosocial services. Clients receive Suboxone (a combination of buprenorphine and naloxone that works to decrease the severity of withdrawal symptoms) on a weekly basis for the first three months of the program and additional services from an interdisciplinary team.

While the CABHI grant is over and the same intensity of services is no longer provided, Horizon Behavioral Health continues to rely on strong partnerships with local community organizations and agencies to identify and connect youth experiencing homelessness to services. For example, Horizon Behavioral Health collaborates with Central

## Horizon Behavioral Health – Adolescent Community Reinforcement Approach Cities of Lynchburg and Amherst, and Appomattox, Bedford, and Campbell Counties, Virginia

Virginia's Coordinated Homeless Intake and Access, a centralized service referrals' entry point for those experiencing or at risk of homelessness. Horizon Behavioral Health similarly partners with the Department of Social Services, Court Service Units, and hospital emergency departments to identify and better serve youth who have been involved with those systems. The organization also partners with local shelters, nonprofits (e.g., Goodwill Industries), food pantries, and soup kitchens—for example, through peer specialist outreach at these locations.

### Outcomes and Other Benefits

During operation of the CABHI program, 90 percent of enrolled youth were offered same-day assessments to identify service needs and begin making connections to appropriate resources and treatment.<sup>131</sup> Data collected during CABHI implementation show that the youth experienced reductions in their mental health symptoms: specifically, significant decreases in the number of days experiencing serious depression and anxiety.<sup>131</sup> In addition, CABHI program participants experienced fewer days with trouble understanding, concentrating, or remembering, and there was a significant increase in the proportion enrolled in school or employed.

### Lessons Learned

- **Meet clients where they are.** Horizon Behavioral Health noted the importance of focusing on youth access to services and conditions that will enhance service engagement. Clients were often hesitant or lacked means to seek services at Horizon Behavioral Health's treatment centers, so instead, therapists and peer specialists would go to them. The A-CRA approach was a particularly good fit because it can be delivered in a wide variety of settings—confidential spaces in shelters, outdoors at a park, at a preferred community location, or even in a car.
- **Take a flexible approach to services.** Horizon Behavioral Health noted that A-CRA, and evidence-based programs in general, should not take a “cookbook” approach. Therapists often needed to revisit topics multiple times with clients, to solidify the underlying skills. At other times, therapists needed to integrate or de-prioritize psychosocial content, to focus on individuals' day-to-day needs and crises. Therapists should also use a case management lens and embed tangible “case management” goals in A-CRA service delivery (e.g., accessing food bank services, helping clients enroll in Medicaid).

### Related Resources

[Horizon Behavioral Health](#)

[Chestnut Health Systems EBTx Center – Community Reinforcement Approach](#)

[Homeless, hopeless, and hungry in Central Virginia: A case study on a wraparound intervention targeting youth homelessness](#)



## Park Center – Peer Specialists

Nashville, Tennessee

### Program

Park Center is a nonprofit mental health organization that has provided support for adults with SMI and co-occurring mental health disorders and substance use since 1984. Located in Nashville, Tennessee, Park Center offers treatment, recovery support, housing, day programs, homeless outreach, and employment services, with the aim of empowering people with mental health disorders and/or SUDs to live and work in their communities. In 2006, Park Center implemented the Homeless Outreach Program to provide more support to people in the community who were experiencing homelessness.

### Challenge

In recent years, Nashville's population has increased significantly, adding to the demand for housing. With limited affordable housing available, residents of Nashville often lose their housing and can end up experiencing sheltered and unsheltered homelessness. Based on the 2022 Point-in-Time Count, approximately 33 percent of the Nashville population experiencing homelessness lived in unsheltered settings. Often, these temporary settings are far away from medical and behavioral healthcare clinics, or individuals who are homeless lack transportation to get to these clinics. Park Center estimates that approximately 48 percent of Nashville's homeless population has a mental illness, creating a potential large treatment gap for behavioral disorders.<sup>132</sup>

### Intervention

To effectively provide mental health and substance use services to people who are experiencing unsheltered homelessness (referred to as “members”), Park Center relies on **peer specialists** who have experienced homelessness, mental health disorders, and/or SUDs. Across the organization, Park Center hires peers in various roles, including outreach staff, data analysts, treatment support coordinators, and supervisors; they perform similar activities to non-peers in these roles. Across these positions, peers help normalize conversations about experiencing mental health disorders, SUDs, and homelessness, both within the culture of Park Center and with members. Peers can receive training through the [Certified Peer Recovery Specialist Program in Tennessee](#) and become a Certified Peer Recovery Specialist (CPRS). As a CPRS, peers are trained in providing trauma-informed care approaches and motivational interviewing techniques. At present, nine staff members have attended the training and seven have become certified. Not all people with lived experience choose to obtain the CPRS certification.

Many peers, both with or without certification, work as outreach staff on Park Center's Homeless Outreach team, which offers services to individuals experiencing a housing crisis or living in encampments and other unsheltered settings. The Homeless Outreach team provides street outreach that assists members in obtaining vital records, advocacy, transportation, and housing. It also helps get them connected with community resources, such as obtaining food security; receiving medical, mental health, substance use treatment; and applying for Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) benefits through the SSI/SSDI Outreach Access and Recovery (SOAR) model.

### Implementation

Park Center creates an environment that values lived experience among their staff, and one in which peers are integral to the staffing structure, rather than considered an “add-on” component. Peers show members what may be possible for them if they have access to the types of services Park Center offers. Peers may not have prior experience providing social services, but their lived experience brings value to the team, and they are compensated at an equal or greater level than non-peer staff, based on their experience. Park Center recognizes that staff members' racial, ethnic, gender, and other identities are also important to their lived experiences. Park Center examines the types of populations they serve and hires peers who reflect their members.

## Park Center – Peer Specialists

### Nashville, Tennessee

Park Center leverages the connections that peers have with members to introduce them to and build trust with medical professionals and offer street medicine (i.e., medical care to people experiencing unsheltered homelessness that is delivered directly to them in their own environment). In the mornings, street outreach and medical staff provide basic medical care, including overdose prevention. In the afternoons, medical staff meet with members in encampments or other pre-determined locations, to provide medical care. Park Center provides street medicine services in collaboration with a local FQHC. This FQHC has an outpatient **MOUD** program that offers Suboxone, counseling, and case management to support individuals with an opioid use disorder. In June 2022, Park Center added a psychiatric nurse provider to its staff, to provide mental health and substance use services directly to members during street outreach.

### Outcomes and Other Benefits

Members are more likely to connect and talk with peers because of their lived experiences, which builds the trust needed to engage someone in behavioral health services within a short time frame. In fiscal year (FY) 2020/2021, 19 Park Center staff served 423 members across the organization. There were 3,257 total contacts and 701 total face-to-face contact hours with members. At the time, there were only three trained CPRSs, who together spent 194 direct contact hours. During FY 2021/2022, 31 staff served a total of 460 members and spent over 1,014 hours on face-to-face patient care. As of May 2022, Park Center increased the number of trained CPRSs to seven, and provided 407 hours of direct patient care to members.

### Lessons Learned

- **Integrate peers** across work. Incorporating the voices of peers into an organization is vital for providing services to members; peers bring lived experiences of the situations that members face and understand the nuances of the services that members need. Peers can help normalize mental health disorders and/or SUDs among both members and staff, thus helping members feel safe interacting with staff and more open to receiving services.
- **Consider the physical environment of providing support.** When addressing the behavioral health needs of people experiencing homelessness, peers and other staff need to understand and work with members to resolve the practical needs and challenges of living on the street, such as medication storage, tolerating negative medication side effects, and ability to access resources consistently.

### Related Resources

[Park Center Homeless Outreach](#)

[Tennessee's Certified Peer Recovery Specialist Program](#)





## Resources for Evaluation

### Overview

Program assessment can occur at varying levels of depth and rigor, through multiple approaches, and for different purposes. **Evaluation** can answer important questions about which aspects of a program are working and those that may require modifications. Evaluation can also help identify whether programs are being implemented as intended and show how individuals are impacted by the intervention. This information can be helpful in making implementation adjustments, if necessary. Evaluation can also demonstrate the value of that intervention to justify its continuation and secure additional funding. As described below, evaluation types vary regarding whether or not they can be used to make causal inferences, such as to assess whether a program serving individuals experiencing homelessness was successful in reducing the severity of symptoms of distress or some other behavioral health outcome.

In contrast, **continuous quality improvement** (CQI) is the process of assessing program or practice implementation and short-term outcomes, and then involving program staff to identify and implement improvements in service delivery and organizational systems to achieve better outcomes. The data collected as part of CQI can overlap with data that might be collected as part of a more structured evaluation plan. Ideally, evaluation findings are also used to improve the implementation and quality of programs, but this

feedback process typically takes much longer because it relies on a more involved process of data collection, cleaning, analysis, and reporting.

Evaluation and CQI are both important components of implementing programs, as they enable organizations to understand both how their programs are working and their impact or success. For organizations working with individuals experiencing homelessness, a combination of evaluation approaches and CQI may offer the best option to assess and improve support for clients.

This chapter provides an overview of different types of evaluation approaches that behavioral health and housing providers can use to assess implementation of behavioral health interventions for individuals experiencing homelessness. The chapter also identifies considerations that are important for this population of individuals and includes a summary of outcomes and possible measures that may be relevant to assess progress toward recovery.

### Types of Evaluation

Evaluations can be **formative** (conducted prior to or during implementation) or **summative** (conducted once the organization has implemented the program/intervention). Summative evaluations can encompass fidelity, processes, outcomes, or impact. Evaluations can have different purposes, as described below.

## Types of Evaluations



**FORMATIVE EVALUATIONS** assess the readiness of an organization to implement a program/intervention, articulate a theory of change (often illustrated in a logic model), and determine the extent to which evaluators will be able to obtain data to assess a program's implementation and outcomes. Staff can also use what is learned during formative evaluations to make mid-course corrections to the program so that it reaches the intended audience or achieves desired results.



**FIDELITY EVALUATIONS** measure the extent to which the delivery of an intervention adheres to the protocols and program model originally developed. Fidelity evaluations identify and measure the core components, activities, and processes of the intervention to identify discrepancies. This can be particularly useful when making sense of unsuccessful outcomes, to assess whether the result truly reflects the intervention or was due to not implementing the intervention with fidelity.



**PROCESS EVALUATIONS** collect and analyze data about the implementation of a program. Process evaluations enable leaders and/or program managers to assess whether they have implemented the program as planned and if (and to what extent) the program reached the intended audience. Process evaluation, namely continuous quality improvement (CQI), also documents factors that support implementation and implementation challenges or barriers (e.g., Is programming trauma-informed?). Organizations may conduct a process evaluation concurrently with an outcome or impact evaluation.



**OUTCOME EVALUATIONS** collect baseline data and data at defined intervals (e.g., monthly, quarterly, yearly) during and after full implementation of the program to assess short- and long-term outcomes. These outcome data provide leaders and/or program managers with information to assess changes or improvements in attitudes and behaviors that can be associated with the program.



**IMPACT EVALUATIONS** assess whether outcomes can be attributed to the program. Impact evaluations seek to establish a causal relationship between a program and the observed outcomes. However, impact evaluations often can be challenging, time-consuming, and expensive to implement.

## Evaluation Considerations

### Adjusting Evaluation to Accommodate the Transitional Nature of Homelessness

The feasibility of rigorous outcome and [impact evaluations](#) among individuals experiencing homelessness in sheltered and unsheltered settings will depend on many factors, including whether a formal “program” or intervention is implemented. Regardless of the nature of the intervention, several of the evaluation approaches described above can be useful in assessing a program’s effectiveness in promoting access to and use of behavioral health supports for individuals while they await housing.

In particular, a [process evaluation](#) or **continuous quality improvement** may be appropriate to assess whether interventions are reaching the intended audience. Evaluators may need to modify evaluation activities to accommodate the contextual factors of

working with people experiencing homelessness. Considerations include:

- **Timing.** Services provided to people experiencing homelessness may occur at irregular intervals, and systematic assessment (e.g., at defined time intervals) may not be possible in the way that is preferable for an [outcome evaluation](#). Those obtaining data should be prepared for missing data and data gaps that result from irregular contact.
- **Engagement.** Given the potential reluctance of people to engage in services, data collection as a discrete task may not be the best use of client time and may decrease willingness of clients to interact with providers. For some people, establishing a relationship will take priority over everything else, and formal assessments (such as those on symptoms or beliefs) should not be administered if they could in any way jeopardize the relationship with the provider.



- **Trust.** Often, an external evaluator is viewed as able to obtain the most objective information from program participants, especially if questions are asked about satisfaction with services. Given the transitory nature of the population, potential hesitancy to trust new people, and the challenge of locating and connecting with people from a logistical standpoint, it may be necessary for providers to collect information instead of an external evaluator. Provider data collection may reduce the external validity of the data but may be preferable to having no data at all.
- **Privacy.** At times, support provided to people experiencing homelessness may occur in shelters, in tent communities, on the street, and in similar settings with others present. When asking questions about symptoms and behaviors, care should be taken to do so in a way that respects the privacy of the individual.
- **Planning.** Ideally, evaluation and the data needed to inform it should be considered prior to program implementation so there is a plan to collect accurate and robust data from the outset, keeping in mind the above-mentioned challenges to this process.
- **Trauma-informed evaluation.** People experiencing homelessness are at higher risk for exposure to traumatic events. Therefore, evaluations must be trauma-informed. The Amherst H. Wilder Foundation provides a [tip sheet](#) on trauma-informed data collection for evaluation purposes. While keeping in mind the caveats noted above, adding measures that screen for traumatic experiences can be helpful in designing and modifying programming to better meet the needs of this population.
- **Evaluation design and definition of success.** Ideally, the population of focus (in this case, people experiencing homelessness and in need of mental health and substance use support) should be involved in identifying outcome indicators. When participants help define “success” of a program or intervention, evaluation data can have more validity. If a program has peers engaged in providing services, these individuals (especially if they have experienced homelessness themselves) can help identify key indicators that may go beyond standard measures of symptoms and stability.

## Conducting Culturally Responsive and Equitable Evaluation

As highlighted in [Chapter 1](#), there are disproportionate rates of homelessness among people of color. These discrepancies make it even more salient for evaluation activities to examine whether the program is equitably implemented and benefits all individuals.

Equitable evaluation is [culturally responsive evaluation](#). Equitable evaluation does not consider culture as a subjective factor that needs to be controlled; instead, it explicitly acknowledges culture and context when assessing program effectiveness. Equitable evaluation relies heavily on engaging with the program participants for whom the evidence-based program or practice is being implemented and from whom evaluation data are collected. According to the [Equitable Evaluation Initiative](#) (EEI), evaluation efforts should be in service of equity, and evaluators should consider the following aspects while developing their evaluation approach:

- Diversity of their evaluation teams, including cultural backgrounds, disciplines, beliefs, and lived experiences
- Cultural appropriateness and validity of evaluation methods
- Ability of the evaluation design to reveal structural and systems-level drivers of inequity (present-day and historical)
- Degree to which communities have the power to shape and own how evaluation happens

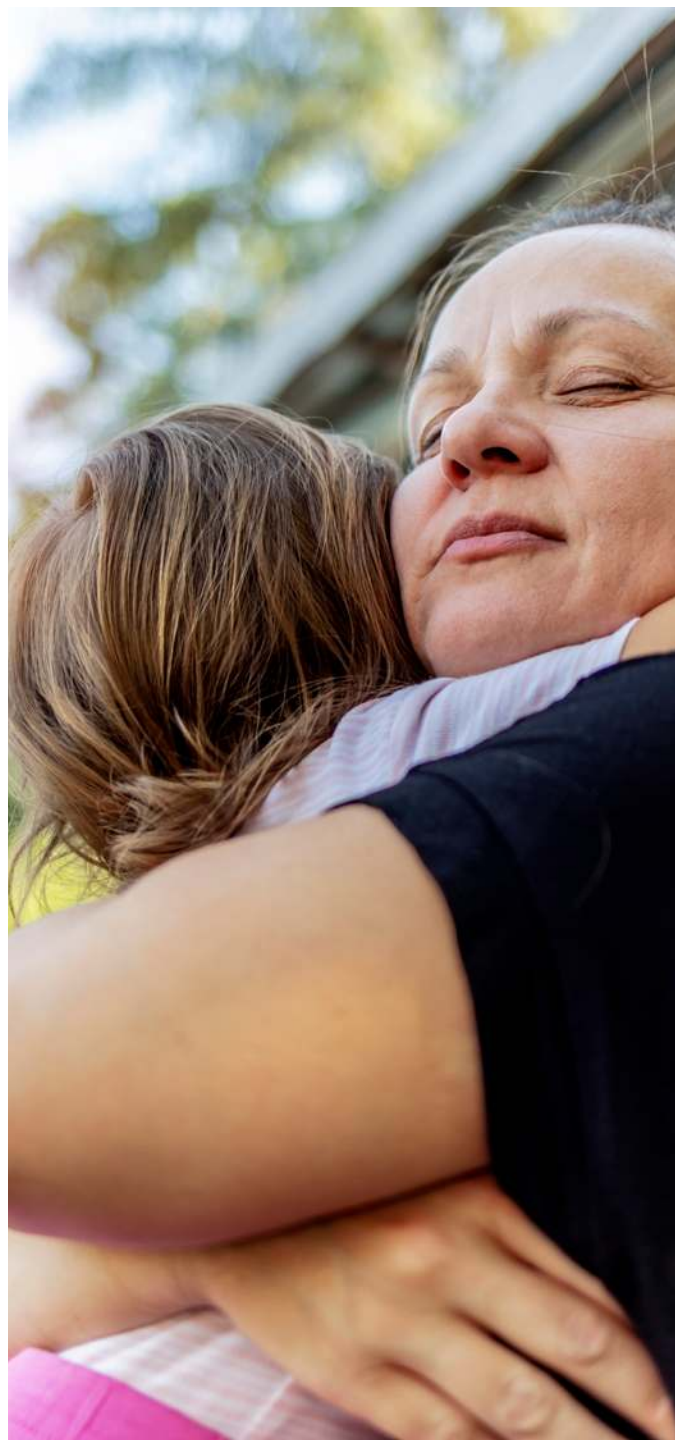
The EEI also states that evaluative work can and should answer critical questions. Given the diverse racial composition of individuals experiencing homelessness, programs may also wish to collect data to understand the effect racial differences have on issues such as:<sup>133</sup>

- Referral patterns for services
- Retention in programs
- Engagement with services
- Reasons people exit programs or discontinue services

These types of questions, through an equitable evaluation lens, will help identify structural or other biases that may affect service systems and help sustain equitable service delivery.

## Continuous Quality Improvement

Continuous quality improvement (CQI) can address some of the considerations above and be used with the help of program staff to systematically identify, document, and analyze barriers and facilitators to implementation. It's an important tool for improving outcomes.



### WHAT IS CQI?

CQI involves a systematic process of assessing program or practice implementation and short-term outcomes and then involving program staff to identify and implement improvements in service delivery and organizational systems to achieve better outcomes. CQI helps assess practice fidelity (the degree to which a program delivers a practice as intended).

CQI differs from process evaluation in that it involves quick assessments of program performance, timely identification of problems and potential solutions, and implementation of small improvements to enhance treatment quality. CQI is usually conducted by internal staff. Process evaluation involves longer-term assessments and is best conducted by an external evaluator.

### WHY USE CQI?

CQI takes a broad look at the systems in which programs or practices operate. Because of the pivotal role it plays in performance management, agencies beginning to implement new treatment, case management, and recovery practices for individuals experiencing homelessness may benefit from CQI procedures.

### WHAT ARE THE STEPS INVOLVED IN CQI?

Although steps in the CQI process may vary based on objectives, typical CQI steps include:

- 1 Identify a program or practice issue needing improvement and a target improvement goal
- 2 Analyze the issue and its root causes
- 3 Develop a plan to correct the root causes of the problem, including specific actions to be taken
- 4 Implement the actions in the plan
- 5 Review the results to confirm that the issue and its root causes have been addressed and short- and long-term treatment outcomes have improved
- 6 Repeat these steps to identify and address other issues as they arise

Another way to think about the stages are in an action-oriented, cyclical manner, with stages of: planning it (PLAN), trying it (DO), observing the results (STUDY), and acting on what is learned (ACT).

### MODEL FOR IMPROVEMENT



### Sources:

Institute for Healthcare Improvement. (n.d.). *Science of improvement: Testing changes*.

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# Outcomes

An outcome is the change resulting from a program’s implementation. In any type of evaluation, it may take some time to assess the full impact of a program on people experiencing homelessness and the larger community. To assess outcomes, it is equally important to consider collecting accurate baseline data, in addition to post-intervention data. Given that partners may

be involved in collecting these data, a plan for data sharing and confidentiality should be completed prior to implementing an evaluation plan.

The following table provides a list of potential measures for consideration, example outcome indicators, and qualitative and quantitative data sources that implementation teams may use to evaluate evidence-based programs discussed in [Chapter 2](#).

Measure	Illustrative Indicators	Illustrative Data Sources
<b>Process Measures</b>		
<b>Service access</b>	<ul style="list-style-type: none"> <li>Improved access to and use of mental health and/or SUD treatment services</li> </ul>	<ul style="list-style-type: none"> <li>Client self-report/client interviews</li> <li>Provider organization electronic data sources</li> </ul>
<b>Service engagement</b>	<ul style="list-style-type: none"> <li>Number of sessions scheduled</li> <li>Number of sessions attended</li> <li>Number of referrals made to other providers</li> </ul>	<ul style="list-style-type: none"> <li>Attendance/administrative data</li> <li>Provider organization electronic data sources</li> </ul>
<b>Service retention</b>	<ul style="list-style-type: none"> <li>Continued use of services</li> <li>Rate of successful completion of treatment vs. treatment dropout</li> </ul>	<ul style="list-style-type: none"> <li>Attendance/administrative data</li> <li>Provider organization electronic data sources</li> </ul>
<b>Short-Term and Intermediate Mental Health Outcome Measures</b>		
<b>Improvements in adult mental health, well-being, and emotional functioning</b>	<ul style="list-style-type: none"> <li>Attainment of client’s personal goals</li> <li>Decreases in legal involvement</li> <li>Improved daily functioning (including social problems, aggressive behavior, motivation, concentration difficulties)</li> <li>Increased enjoyment of and interest in activities</li> <li>Improved sleep</li> <li>Participation in rehabilitation program, school, or employment</li> <li>Participation in medical appointments and care</li> <li>Reduction of mental health disorder symptoms</li> <li>Reduction or absence of suicidal ideation and self-harm</li> <li>Reduction in feelings of helplessness and hopelessness</li> <li>Stable relationships/social functioning</li> </ul>	<ul style="list-style-type: none"> <li>Client self-report/client interviews</li> <li>Employment administrative data</li> <li>Hospital and medical facility administrative data</li> <li>Justice system administrative data</li> <li>Family/friend observation</li> <li>School administrative data</li> </ul> <p><i>Measurement tools:</i></p> <ul style="list-style-type: none"> <li><a href="#">Beck Depression Inventory (BDI-II)</a></li> <li><a href="#">Generalized Anxiety Disorder 7-Item (GAD-7) Scale</a></li> <li><a href="#">Hamilton Rating Scale for Depression (HAM-D-27)</a></li> <li><a href="#">Modified Global Assessment of Functioning</a></li> <li><a href="#">Patient Health Questionnaire (PHQ-9)</a></li> <li><a href="#">Quick Inventory of Depressive Symptomatology (QIDS)</a></li> <li><a href="#">State Trait Anxiety Inventory (STAI)</a></li> </ul>
<b>Short-Term and Intermediate Substance Use Outcome Measures</b>		
<b>Reduced use of substances (short- and long-term)</b>	<ul style="list-style-type: none"> <li>Amount of use for multiple substances</li> <li>Frequency of use for multiple substances</li> <li>Usage during reference periods (e.g., past 30 days, past year)</li> </ul>	<ul style="list-style-type: none"> <li>Client self-report/client interviews</li> <li>Lab data (e.g., urine screen)</li> </ul> <p><i>Measurement tools:</i></p> <ul style="list-style-type: none"> <li><a href="#">Addiction Severity Index (ASI)</a></li> <li><a href="#">Cocaine Selective Severity Assessment (CSSA)</a></li> <li><a href="#">Maudsley Addiction Profile (MAP)</a></li> <li><a href="#">Timeline Follow-Back Method Assessment (TLFB)</a></li> </ul>

Measure	Illustrative Indicators	Illustrative Data Sources
<b>Short-Term and Intermediate Substance Use Outcome Measures (continued)</b>		
<b>Reduced craving</b>	<ul style="list-style-type: none"> <li>Feeling of craving of either single or multiple substances</li> </ul>	<ul style="list-style-type: none"> <li>Client self-report/client interviews</li> </ul> <p><i>Measurement tools:</i></p> <ul style="list-style-type: none"> <li><a href="#">Brief Substance Craving Scale (BSCS)</a></li> </ul>
<b>Housing Outcome Measures</b>		
<b>Housing status</b>	<ul style="list-style-type: none"> <li>Successful identification and placement in stable housing</li> </ul>	<ul style="list-style-type: none"> <li>Client self-report/client interviews</li> <li>Case manager reports</li> <li>Provider organization electronic data sources</li> </ul>
<b>Continued mental and/or SUD treatment once housed</b>	<ul style="list-style-type: none"> <li>Sustained engagement in and use of mental and/or substance use treatment supports once housed</li> </ul>	<ul style="list-style-type: none"> <li>Client self-report/client interviews</li> <li>Attendance/administrative data</li> <li>Provider organization electronic data sources</li> </ul>

## Resources

### General Program Evaluation and Continuous Quality Improvement

- A [Framework for Program Evaluation](#) from the Program Performance and Evaluation Office at the Centers for Disease Control and Prevention summarizes essential elements of program evaluation.
- The Administration for Children and Families (ACF) provides [several resources](#) to assist in evaluating programs. While originally intended for pregnancy prevention programs, the resources provided are applicable to the area of homelessness as well.
- [The Institute for Healthcare Improvement's Quality Improvement Essentials Toolkit](#) includes the tools and templates to launch a quality improvement project and manage performance improvement.
- The National Learning Consortium offers a primer called [Continuous Quality Improvement \(COI\) Strategies to Optimize Your Practice](#) that focuses on the use of electronic health record implementation and which could be applied to any type of outcome, regardless of the sophistication of the data collection mechanisms available.

### Evaluating Programs That Serve Individuals Experiencing Homelessness

- [Evaluating Programs: Strategies and Tools for Providers Serving Homeless Families](#) is a resource developed by the Conrad N. Hilton Foundation that assists programs serving individuals experiencing homelessness to build evaluation activities into their programming.
- A free, six-hour online training course developed by the Canadian Observatory on Homelessness titled [Program Evaluation for the Homelessness Sector](#) supports managerial staff in better understanding, documenting, and communicating the impacts of their work.
- [Strategies to End Homelessness: Current Approaches to Evaluation](#), from the Canadian Observatory on Homelessness, provides a summary of research on interventions that aim to end or reduce homelessness, with an in-depth look at the evaluation approaches used.
- [The West Coast Convening Framework Practical Guide to Outcomes Measurement for Programs Serving Youth and Young Adults Experiencing Homelessness](#) provides information to measure outcomes to facilitate results-driven care, data sharing, and cross-agency analysis.

- SAMHSA/National Institute on Drug Abuse provides a comprehensive guide to [implementing MI with fidelity and how to enhance proficiency](#).
- This [Client Evaluation of Counseling form](#) is a tool to assess clients' feelings on helpfulness of the MI approach.
- [Peers for Progress from University of North Carolina Gillings School of Global Public Health](#) provides several resources to assist in evaluating peer support programs.

- The [Equitable Evaluation Framework™](#) provides a set of principles upon which to understand why and how to conduct culturally responsive evaluation.

### Evaluating Program Sustainability

- The Center for Public Health Systems Science at the Brown School at Washington University in St. Louis has developed a [Program Sustainability Assessment Tool \(PSAT\)](#) and a [Clinical Sustainability Assessment Tool \(CSAT\)](#) to measure progress toward sustaining new implementation efforts.

### Resources on Culturally Responsive and Equitable Evaluation

- The Handbook of Practical Program Evaluation's [Culturally Responsive Evaluation: Theory, Practice, and Future Implications](#) provides a foundation for culturally responsive evaluation, from preparation for evaluation to disseminating and utilizing results.



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# Glossary

**Annual Homeless Assessment Report (AHAR)** is a U.S. Department of Housing and Urban Development (HUD) report to the U.S. Congress that provides nationwide estimates of homelessness, based on data about people who experience homelessness during a 12-month period, point-in-time counts of people experiencing homelessness on one day in January, and data about the inventory of shelter and housing available in a community.

**Assertive Community Treatment (ACT)** is an evidence-based program designed to support community living for individuals with the most severe functional impairments associated with serious mental illness. Services are delivered in a person's home or other community settings. Caseloads are approximately one staff for every ten individuals served. Services are provided wherever they are needed, 24 hours a day, 7 days a week.

**Behavioral health** is the promotion of mental health, resilience, and well-being; the treatment of mental health and substance use disorders; and the support of those who experience and/or are in recovery from these conditions, along with their families and communities.

**Continuums of Care (CoCs)** are programs designed to provide funding for efforts by nonprofit providers and state and local governments to quickly rehouse homeless individuals and families while minimizing the trauma and dislocation homelessness causes for homeless individuals, their families, and communities; promote access to and utilization of mainstream programs by homeless individuals and their families; and optimize self-sufficiency among individuals and families experiencing homelessness.

**Continuous quality improvement (CQI)** is a systematic process of assessing a program or practice implementation and short-term outcomes and then involving program staff to identify and implement improvements in service delivery and organizational systems to achieve better outcomes. CQI helps assess practice fidelity.

**Culturally responsive and equitable evaluation (CREE)** is an evaluation that incorporates cultural, structural, and contextual factors (e.g., historical, social, economic, racial, ethnic, gender) using a participatory process that shifts power to the individuals most impacted.

**Evidence-based practices** are interventions that are guided by the best research evidence with practice-based expertise, cultural competence, and the values of the people receiving the services, that promotes individual-level or population-level outcomes.

**Fidelity** is the extent to which an intervention was delivered as conceived and planned.

**Harm reduction** is a practical and transformative approach that incorporates public health strategies—including prevention, risk reduction, and health promotion—to empower people who use drugs to live healthy, self-directed, and purpose-filled lives.

**Health inequities** are differences in health status or in the distribution of health resources among different population groups, arising from the social conditions in which people are born, grow, live, work, and age.

**Housing First** is an evidence-based approach to reducing homelessness in the United States. The philosophy of Housing First is to connect individuals and families experiencing homelessness quickly and successfully to stable housing without preconditions and barriers to entry, such as sobriety, treatment for mental health and/or substance use disorders, or service participation requirements. Voluntary supportive services are offered to maximize housing stability and prevent returns to homelessness as opposed to addressing predetermined treatment goals prior to stable housing entry.

**Impact evaluation** assesses an intervention’s effectiveness in achieving its ultimate goals. Impact evaluations determine whether, and sometimes to what extent, the newly implemented intervention led to changes in outcomes.

**Lived experience** is personal knowledge gained through direct, first-hand involvement. In the context of this report, lived experience refers to individuals who have experienced mental illness, substance use or substance use disorder, and/or homelessness.

**Outcome evaluation** collects baseline data and data at defined intervals (e.g., annually) during and after full implementation of the intervention to assess short- and long-term outcomes related to the targeted behaviors/indicators.

**Outreach** is a broad term that refers to serving individuals outside a physical structure; for people experiencing homelessness, the service typically is offered in unsheltered settings where the individuals are found.

**Point-In-Time Count (PIT)** is an annual count of sheltered and unsheltered people experiencing homelessness that is collected on a single night in January. The federal government requires that CoCs conduct an annual count of people experiencing homelessness and who are in emergency shelters, transitional housing, and safe havens on a single night.

**Process (implementation) evaluation** assesses the quality of an intervention’s implementation and conditions that facilitate or create barriers to successful implementation. Process evaluation enables program managers and policymakers to assess whether they have implemented the intervention as planned, and whether and to what extent it reached the intended audience.

**Recovery** is a process of change through which people improve their health and wellness, live self-directed lives, and strive to reach their full potential. The four dimensions that support recovery are health, housing, purpose, and community.

**Recovery support services** are a range of non-clinical support services designed to help people with mental health and substance use disorders manage their conditions successfully.

**Serious mental illness (SMI)** is a diagnosable mental, behavioral, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities. SMI includes disorders such as bipolar disorder, major depressive disorder, schizophrenia, schizoaffective disorder, and post-traumatic stress disorder.

**Social determinants of health** are conditions in the environments where people are born, live, learn, work, play, worship, and age that affect health.

**Stakeholders** are individuals, organizations, or communities that have a vested interest in the process and outcomes of a project, research, or policy endeavor/initiative.

**Strengths-based** is an approach to assessment and care that emphasizes the strengths of the individual.

**Structural racism** is defined as a system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing, ways to perpetuate racial group inequity.

**Substance use** refers to the use—even one time—of alcohol or other drugs.

**Sustainability** is the process of building adaptive and effective programs and services that achieve and maintain desired long-term results.

**Trauma-informed** approaches are services or care based on the knowledge and understanding of trauma and its far-reaching implications.

**Under-resourced communities** are population groups or geographic areas that experience greater obstacles to health, based on characteristics such as, but not limited to, race/ethnicity, socioeconomic status, age, gender, disability status, historical traumas, sexual orientation/gender identity, and location.

# APPENDIX 1: Acknowledgments

This guide is based on the thoughtful input of SAMHSA staff and the Technical Expert Panel on Expanding Access to and Use of Behavioral Health Services for People Experiencing Homelessness from November 2021 through July 2022. Two expert panel meetings were convened during this time. A series of guide development meetings were also held virtually over a period of several months.

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## APPENDIX 2: Literature Review Process

**STEP 1.** The search strategy used for this guide began with a broad review of systematic reviews on populations experiencing different types of homelessness (chronic, sheltered, unsheltered) and behavioral health topics (substance use, mental illness, co-occurring, harm reduction). Searches were conducted in five databases: PsycInfo, EBSCO, PROSPERO, PubMed, and MedLine.

**STEP 2.** The team conducted an abstract review of every citation captured from the database searches of systematic reviews (n=273). We systematically reviewed abstracts (or in very rare cases, the entire article if an abstract was not available) according to the following criteria:

- Articles published after 2002, written in English, and conducted in the United States, United Kingdom, Canada, Australia, or New Zealand
- Articles that described an intervention, program, or model focused on improving behavioral health service engagement and use among people (youth, adults, families) experiencing sheltered or unsheltered homelessness

This search excluded studies focused on veteran populations experiencing homelessness, as this population has additional needs for services, which the U.S. Department of Veterans Affairs coordinates.

SAMHSA's National Policy Lab, CSAT/CMHS staff, and subject matter experts identified five behavioral health interventions/approaches as part of this search process. As explained in the report, studies that focused on Housing First and Assertive Community Treatment models were not included. Abstracts were screened for each identified behavioral health intervention/approach and application of the approach with individuals experiencing homelessness during the period prior to being housed.

1. Medication for opioid use disorder (237 abstracts)
2. Motivational interviewing (72 abstracts)
3. Intensive case management (531 abstracts)
4. Community Reinforcement Approach (16 abstracts)
5. Peer support (201 abstracts)

**STEP 3.** The team reviewed and extracted information into a systematic literature review table. Extracted information related to the citation, intervention, setting, study design, outcomes, findings, and lessons learned.

**STEP 4.** The team synthesized findings for each of the five treatment approaches and practices that demonstrated positive behavioral health outcomes (behavioral health service engagement and use) for individuals experiencing sheltered or unsheltered homelessness.

# APPENDIX 3: Descriptions of Included Behavioral Health Interventions

Intervention	Authors, Year	Ref # in List	Study Design, Methods	Population and Setting	Behavioral Health Outcomes	Housing Outcomes	Timing of Assessment
MOUD	Chatterjee, A., et al., 2017	65	Retrospective chart review	Families experiencing homelessness living in a family shelter in Massachusetts.	Reduction in opioid use according to urine drug test; reduction in unprescribed controlled substance use; increase in employment; reduction in rate of overdose	N/A	Before treatment vs. third month of treatment
MOUD	Lashley, M., 2019	69	Descriptive report	Men experiencing homelessness and living at a residential recovery program in Baltimore, Maryland.	Continued engagement in recovery	N/A	N/A
MOUD	Tringale, R., et al., 2015	70	Descriptive report	People experiencing homelessness who visited the needle exchange program and the Center for Harm Reduction of Homeless Healthcare Los Angeles.	Continued engagement in treatment	N/A	N/A
MOUD	Alford, D.P., et al., 2007	60	Retrospective chart review	People experiencing homelessness with opioid use disorder in Massachusetts.	Continued engagement in treatment; continued attendance of additional behavioral health services, such as substance use counseling and group therapy; decreased opioid use; increased rates of employment	N/A	Assessments completed at 3, 6, 9, and 12 months
MOUD	Carter, J., et al., 2019	58	Retrospective chart review	People experiencing homelessness with opioid use disorder in San Francisco.	Continued engagement in treatment: 63% of patients were retained in care at 1 month, 53% at 3 months, 44% at 6 months, 38% at 9 months, and 26% at 12 months	N/A	Assessments completed at 1, 3, 6, 9, and 12 months
MOUD	Fine, D.R. et al., 2021	66	Retrospective chart review	People experiencing homelessness with opioid use disorder in Boston.	Continued engagement in treatment; past month OBAT attendance associated with lower mortality risk (adjusted hazard ratio, 0.34; 95% CI, 0.21-0.55, P<.001)	N/A	Assessments completed at 1, 6, and 12 months
MOUD	O'Gurek, D.T. et al., 2021	68	Retrospective chart review	People experiencing homelessness and opioid use disorder in geographic areas of Philadelphia identified as having high fatal overdose rates.	Continued engagement in treatment: 61.2% (n=90/147) of patients were retained in care at 1 month, 36.6% (n=30/82) at 3 months, and 27.6% (n=8/29) at 5 months	N/A	Assessments completed at 1, 3, and 5 months
MOUD	Weinstein, L.C., et al., 2020	67	Retrospective chart review	People experiencing homelessness and opioid use disorder in Philadelphia.	Continued engagement in treatment: a 3-month retention rate of 82% and a 6-month retention rate of 63%	N/A	Assessments completed at 3 and 6 months
Brief Motivational Interviewing	Baer, J.S., et al., 2008	78	RCT	Youth (ages 13 to 19) who lack stable housing and reported substance use in 30 days prior. Participants were recruited from a nonprofit, faith-based drop-in center, which is also where MI was delivered.	Increased service utilization at 1-month follow-up, but no longer significant at 3-month follow-up	N/A, not measured	1-month and 3-month follow-ups
Motivational Interviewing (AWARE)	Tucker, J.S., et al., 2017	79	RCT	Youth (ages 18 to 25) seeking services at one of two drop-in centers for youth experiencing homelessness in Los Angeles County. Sessions were also delivered at the drop-in centers.	Reduced frequency of alcohol use*, greater readiness/confidence to reduce/quit other drug use	N/A, not measured	3-month follow-up

Intervention	Authors, Year	Ref # in List	Study Design, Methods	Population and Setting	Behavioral Health Outcomes	Housing Outcomes	Timing of Assessment
Brief Motivational Interviewing	Peterson, P.L., et al., 2006	73	RCT	Youth experiencing homelessness (ages 13 to 19) with unstable housing and at least one binge drinking episode or illicit drug use in the past 30 days. Youth were recruited from street intercept locations, agencies serving youth experiencing homelessness, or through word of mouth/posted flyers. Interviews were conducted at one of two field-site offices located in areas frequented by youth experiencing homelessness.	Reduced drug use other than marijuana	N/A, not measured	1-month follow-up
Motivational Interviewing	Slesnick, N., et al., 2013	80	RCT	Runaway youth (ages 12 to 17) with a participating parent/legal guardian, meeting criteria for alcohol or drug abuse/dependence. Participants were recruited from a runaway shelter that provided short-term crisis shelter and services. Therapy was conducted in the home. CRA therapists were master's-level clinicians or graduate students in couples and family therapy.	No significant findings	N/A, not measured	Assessments completed at 3, 6, 9, 12, 18, and 24 months after baseline assessment
Motivational Interviewing (The Power of YOU)	Wenzel, S.L., et al., 2009	81	Qualitative outcomes study	Young adult women (ages 18 to 25) who were staying in homeless shelters in Los Angeles County. Therapy and focus groups were conducted at the shelter.	N/A, qualitative study	N/A, qualitative study	N/A
Intensive Case Management	Buck, D.S., et al., 2011	85	Program evaluation	Individuals detained in the Harris County Jail experiencing homelessness and mental disorders referred to the Jail Inreach Project for ICM.	More than half of the persons referred to the program remained successfully linked with services post-release	N/A, not measured	N/A
Intensive Case Management	Gordon, R.J., et al., 2012	86	Observational study	Individuals included in the 18-site Access to Community Care and Effective Services and Supports (ACCESS) national demonstration study.	Young, middle-aged, and older subjects had improvements in housing, substance use, and psychiatric outcomes; rates of psychiatric symptoms improved the most among young adults	N/A, not measured	12 months after baseline
Adolescent Community Reinforcement Approach	DiGiuseppi, G.T., et al., 2021	97	Retrospective matched QED	Pooled data from the Global Appraisal of Individual Needs (GAIN), a longitudinal substance use treatment dataset, including longitudinal assessment data from adolescents and young adults (ages 12 to 25) who reported one or more days homeless in the 90 days prior to treatment; there are 213 U.S. sites from 2002 to 2012 contributing data to GAIN.	No significant findings	N/A, not measured	3, 6, and 12 months post-intake
Community Reinforcement Approach	Slesnick, N., et al., 2007	96	RCT	Street living youth aged 14 to 22 recruited from a drop-in center in Albuquerque, NM. All youth met DSM-IV criteria for alcohol or other substance use disorders and met criteria for homelessness. CRA was delivered at the drop-in center by master's-level professional counselors.	Significant reduction in reported substance use, reduced depression*, fewer internalizing problems	Significantly increased "social stability" (measured by the percent days in the period of work, education, being housed, and seen for medical care)	3 and 6 months after baseline

Intervention	Authors, Year	Ref # in List	Study Design, Methods	Population and Setting	Behavioral Health Outcomes	Housing Outcomes	Timing of Assessment
Community Reinforcement Approach	Slesnick, N., et al., 2015	95	RCT	Adolescents and young adults (ages 14 to 20) experiencing homelessness who met the criteria for abuse or dependence for alcohol or other drugs. Treatment was delivered at a local drop-in center.	Significant reduction in frequency of drug use compared to case management condition, as measured on the treated sample	N/A, not Measured	3, 6, and 12 months post-intake
Community Reinforcement Approach	Slesnick, N., et al., 2013	80	RCT	Runaway youth (ages 12 to 17) with a participating parent/legal guardian, meeting criteria for alcohol or drug abuse/dependence. Participants were recruited from a runaway shelter that provided short-term crisis shelter and services. Therapy was conducted in the home. CRA therapists were master's-level clinicians or graduate students in couples and family therapy.	No significant findings	N/A, not measured	Assessments completed at 3, 6, 9, 12, 18, and 24 months after baseline assessment
Peer Support	Corrigan, P.W., et al., 2017	101	RCT	African Americans with SMI who were experiencing homelessness (based on self-report). Participants were recruited from clinics and homeless shelters. Peer navigation was delivered in places and at times convenient for clients. Participants had cell phones or access to phones because of citywide social service effort.	Significant impact on psychological experience of physical health, recovery (based on scores on Recovery Assessment Scale), and psychological distress	Significantly less homelessness for both the intervention and control group; nonsignificant difference between both groups at 12 months	Measures completed at 4, 8, and 12 months after the baseline assessment
Peer Support	Parkes, T., et al., 2022	102	Mixed methods	People experiencing homelessness and substance use. Peer navigation occurred in three outreach services in Scotland and three Salvation Army (TSA) hostels (Lifehouses) in England.	Proportion of clients currently engaged in opioid substitution therapy increased from 57% to 67% from baseline to follow-up and showed a reduction in injection risk behavior (36% baseline; 7% follow-up); improved mental health outcomes and reduction in severity of self-reported depression and anxiety from baseline to follow-up (based on Patient Health Questionnaire and General Anxiety Disorder measure scores); positive outcomes on recovery; higher levels of recovery capital (based on the Substance Use Recovery Evaluator scale)	N/A	Baseline (October 2018 to May 2019) and follow-up (August to November 2019)

## APPENDIX 4: SAMHSA Resources

SAMHSA's work includes programs that specifically provide support to individuals experiencing homelessness (PATH, GBHI, TIEH) and provides resources for providers (HHRC and SOAR).

- The [Projects for Assistance in Transition from Homelessness \(PATH\) program](#) provides funds to all 50 states and six territories to support services for people with serious mental illness (SMI) and co-occurring SMI and substance use disorder (SUD) who are experiencing or at imminent risk of homelessness, including outreach and engagement, screening and referrals, housing support, and other services.
- The [Grants for the Benefit of Homeless Individuals \(GBHI\) program](#) provides funds to communities to expand community treatment and recovery services for individuals, youth, and families experiencing homelessness who have SUD or co-occurring mental health disorders and SUD. GBHI also funds coordination of housing and supportive services, as well as engagement and enrollment of clients in health insurance.
- The [Treatment for Individuals Experiencing Homelessness \(TIEH\) program](#) provides funds to states, federally recognized tribes and tribal organizations, and nonprofit organizations to increase access to evidence-based treatment services, peer support, recovery support services, and housing support services for people experiencing homelessness who have SMI, serious emotional disturbance, or co-occurring disorders.
- The [Homeless and Housing Resource Center \(HHRC\)](#) provides training on housing and treatment models focused on adults, children, and families who are experiencing or at risk of homelessness and have SMI and/or serious emotional disturbance, SUD, and/or co-occurring disorders.

- The [SSI/SSDI Outreach, Access, and Recovery \(SOAR\) program](#) 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 SMI, medical impairment, and/or a co-occurring SUD.

SAMHSA's [practitioner training](#) offers tools, training, and technical assistance to practitioners in the fields of mental health and SUDs, including highly relevant topics, such as suicide prevention; services for people with mental health disorders and/or SUDs who come into contact with the adult criminal justice system; information on supporting the population of people identifying as lesbian, gay, bisexual, transgender, queer, questioning, intersex, two-spirit, and other diverse sexual orientations, gender identities, and expressions (LGBTQI+); training and technical assistance related to SUD recovery; and integration of primary and behavioral health care. These centers and programs include a wealth of training resources and materials that are freely available for public use.

SAMHSA also offers hundreds of [publications](#) on a wide range of topics related to mental illness (e.g., drug abuse, alcohol abuse, trauma, suicide, co-occurring disorders, depression, post-traumatic stress disorder, anxiety disorders, psychosis, schizophrenia) and treatment, prevention, and recovery.

Photos are for illustrative purposes only.  
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