NEW YORK STATE | Office of Mental Health

Safe Options and Person-Centered Approaches to Addressing Homelessness

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NYS Office of Temporary and Disability Assistance (OTDA)

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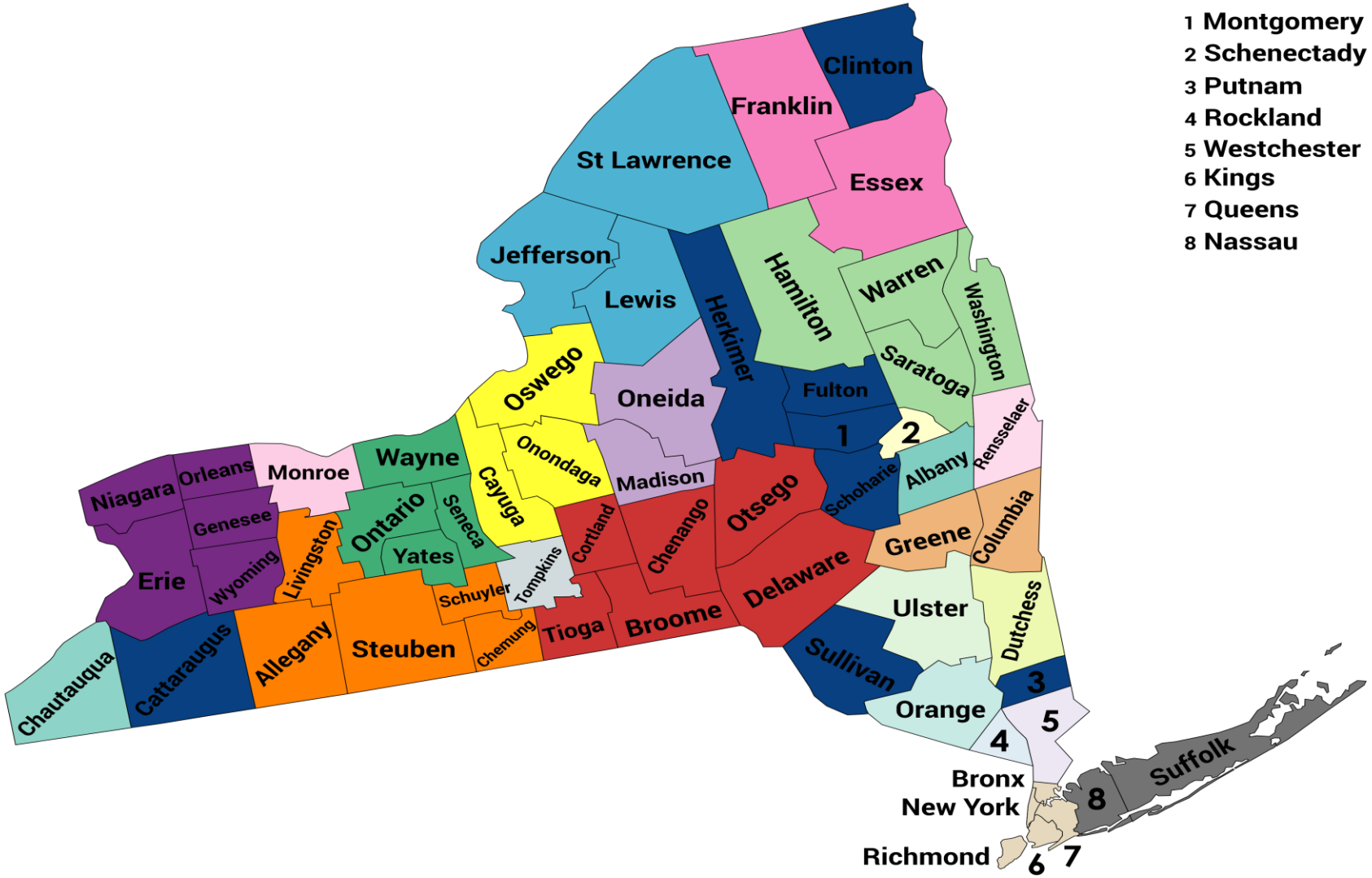
- OTDA oversees all 58 Social Service Districts
- Shelter oversight and payment is through the District
- NYS pays for emergency shelter stays using Public Assistance (PA) funding and TANF eligibility requirements.
- Outside of NYC, a person must be eligible for TANF for the district to find and pay for an emergency shelter placement
- PA for singles has a state and local share
- Most counties in NYS do not have an emergency shelter and use hotels and motels
- NYS started paying for emergency shelter placements on Code Blue nights in 2016 (no local share and no eligibility component)

NYS Office of Temporary and Disability Assistance (OTDA)

- Code Blue brought to light challenges with New York's emergency shelter response system
- SOS CTI helps address some of those challenges
- OTDA's role with SOS CTI
- Collaborative approach to local homeless system response
  - Local districts – first stop for people experiencing homelessness
  - Continuums of Care – Coordinated Entry
  - SPOA
  - Existing homeless services providers
  - Existing street outreach
  - Existing PSH opportunities and subsidy programs

Map of Continuums of Care in NYS



State Level Point in Time Count Data (2024)

- New York State PIT count numbers are at an all-time high of 158,019 people with the Rest of State (RoS) having an overall count of 17,885 and New York City (NYC) having an overall count of 140,134.
  - RoS increased by 2,710 people (18%).
  - NYC increased by 52,109 people (59%).
  - New York State, as a whole, increased by 54,819 people (53%).

- 5,638 people experiencing unsheltered homelessness in NYS.
  - 631 person increase from 2023 (13% increase).

County Level Point in Time Count Data (2024)

Location	2023 Overall	2024 Overall	Number Increase	Percent Increase
Monroe	803	1,056	253	32%
Sullivan	132	300	168	127%
Ulster	435	617	182	42%
Rest of State	15,175	17,885	2,710	18%

Rates of Homelessness (2024)

Location	Homelessness Per 10,000 People	Sheltered PIT Estimates	Unsheltered PIT Estimates	Population Estimates (Census Data)
Monroe	**14**	976	80	752,202
Sullivan	**37**	291	9	80,450
Ulster	**34**	553	64	182,977
US	**23**	497,256	274,224	340,110,988
Rest of State	**15**	16,644	1,241	11,389,176

County Demographics

County Size

- Ulster – 1,124 sq miles
- Sullivan – 968 sq miles
  - NYC = 300 sq miles

Population Density

- Ulster – 161 / sq mile
- Sullivan – 81 / sq mile
  - NYC= 29,302

- Short Term Rentals in Ulster County increased 56% between 2019 and 2022

Safe Options Support (SOS) Program: CTI Teams

Safe Options Support (SOS) Teams

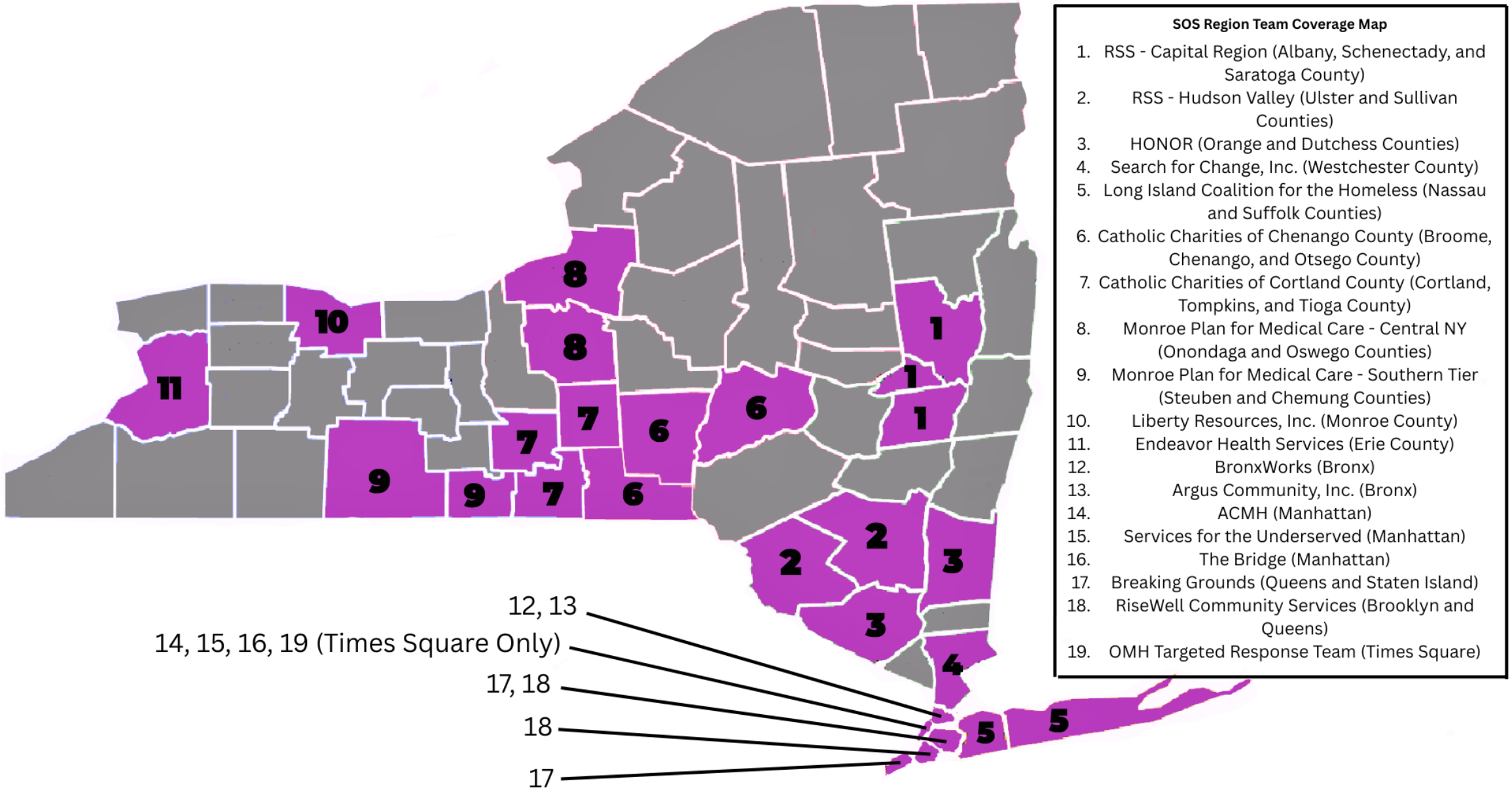
- Multidisciplinary teams using Critical Time Intervention approach to provide intensive outreach, engagement, and care coordination services to unhoused individuals until stably housing (approx. 9-12 months).

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

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

Safe Options Support (SOS) Teams

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



SOS Region Team Coverage Map

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

Eligibility & Enrollment

Eligibility & Enrollment

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

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

Eligibility & Enrollment

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

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

Safe Options Support Model

What is Safe Options Support?

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

Services Offered Through SOS Outreach

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

Engagement

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

Information & Referral

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

Direct Services

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

SOS Care Coordination

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

SOS Multi-Phased Model

SOS Data & Outcomes

SOS Data & Outcomes

In NYC, from April 2022 – May 2025:

- Over 62,000 outreach encounters
- Nearly 2,400 individuals placed in Safe Haven / shelter
- Approximately 5,280 referrals received
- 2,593 individuals enrolled into SOS services.
- 758 individuals have obtained stable housing

Outside NYC, from Fall 2023 – May 2025:

- Over 24,000 outreach encounters
- Nearly 400 individuals placed into temporary shelter
- Over 3,800 referrals received
- 705 individuals enrolled into SOS services.
- 394 individuals have obtained stable housing

Low Barrier Supportive Housing

Eligibility & Enrollment

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

Housing Data & Outcomes

- Between Oct. 2023 – May 2025, approx. 270 people have been admitted into low barrier supportive housing units.

- Of those SOS members admitted, 260 remain stably housed.

Ulster/Sullivan SOS CTI Team

Challenges Faced by Rural SOS Teams

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

Challenges Faced by Rural SOS Teams

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

How Have We Adjusted?

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

How Have We Adjusted?

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

How Have We Adjusted?

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

How Have We Adjusted?

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

Role of the Peer Specialist

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- Peer Role
  - *Within team structure*

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

- Success Stories
  - *Outreach*
  - *Enrolled*

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

Questions?

Office of Mental Health