COVID-19 Homeless System Response:
Evidence-based Service Delivery

- *EBPs are linked to predictable, beneficial outcomes for clients.*
- *Implement EBPs with fidelity to the model.*

Evidence-based practice (EBP) is a term denoting a rigorously and scientifically evaluated practice designed to achieve specific outcomes. During this time of COVID-19, it is important to use practices that are proven to promote independence, resiliency, and continued stability. The principles of equity should be woven into all EBPs and caseworkers should listen to each client in order to understand and support individual needs that may be related to culture, race, or socioeconomic status. Caseworkers should also recognize that ongoing violence toward and oppression of Black, Indigenous, and people of color (BIPOC) has likely created additional stress for clients, worsening the effects of the concern over COVID-19. Following are examples of EBPs that have proven effective when used with people who have experienced homelessness as well as behavioral health disorders.[1]

Housing First

Housing First is an EBP that offers immediate access to permanent housing without preconditions for people experiencing homelessness who also have disabilities. Voluntary, supportive services are offered to help tenants maintain their housing. The approach is guided by the belief that people must have their basic needs met before they can begin to make needed changes in their lives. The goals of Housing First are to help people obtain housing quickly, increase self-sufficiency, and remain housed. Housing First is particularly important during COVID-19 as public health officials and service providers work to de-congregate shelters, encampments, and other population-dense areas to minimize the risk of virus transmission. Two common models use the Housing First approach, although they vary in the way the practice is implemented. Permanent Supportive Housing (PSH) is targeted to individuals and families with chronic disabilities—including mental health or substance-use disorders—who have also experienced long-term or repeated homelessness. It provides long-term rental assistance and supportive services. Rapid rehousing (RRH) is used to assist a wider variety of participants, including families. RRH provides short-term rental assistance and services. The core components of both PSH and RRH—housing identification and assistance with rent, moving, case management, and services—all operationalize Housing First principals. For more information, visit the National Alliance to End Homelessness.

Critical Time Intervention (CTI)

CTI was developed in the 1980s when many people with serious mental illness (SMI) were becoming homeless. Clinicians, researchers, and advocates observed that many people who had been housed returned to homelessness. CTI is a short-term intervention for people adjusting to a "critical time" of transition. CTI provides for long-term community supports and resources. The CTI team maintains continuity of care during the first nine months of transition, while simultaneously passing responsibility onto community supports. This means that support will remain after intervention, extending the effects of a time-limited intervention. Randomized trials have found that returns to homelessness were dramatically reduced for several people that were offered CTI. For more information, visit the Center for the Advancement of Critical Time Intervention.

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[1] These practices are described in the Substance Abuse and Mental Health Services Administration's Treatment Improvement Protocol-55:https://store.samhsa.gov/product/TIP-55-Behavioral-Health-Services-for-People-Who-Are-Homeless/SMA15-4734

Assertive Community Treatment (ACT)

The Substance Abuse and Mental Health Services Administration (SAMHSA) offers the Assertive Community Treatment Evidence-Based Practices Kit with tools and guidance to facilitate implementation. ACT is a highly individualized practice that offers customized, community-based services for people living with SMI. This EBP is for people with the most challenging and persistent behavioral health problems. ACT originally addressed the needs of people discharged from inpatient care in stable condition who then returned to inpatient care soon after. This EBP includes multidisciplinary teams that offer the support, treatment, and rehabilitation services needed to help vulnerable people thrive in the community. The types, intensity, and length of time for services all vary. Services are voluntary, individualized, and dependent upon client needs. This practice means providing what is needed, when it is needed—24 hours a day, 7 days a week—to help people achieve long-term stability. Services are not time-limited and ACT is characterized by small, often shared, caseloads. Outcomes include reduced self-reported psychiatric symptoms, hospital stays, and emergency department visits.

Motivational Interviewing (MI)

MI is a therapeutic approach focused on behavior change faciltated by a collaborative relationship between a coach and a client. The intent is to promote readiness to change harmful behaviors by engaging in discussions about a person's reasons for or against change. The goal is to help clients recognize the negative effects of risky behaviors, including substance use. MI coaches avoid challenging resistance and support the client's self-efficacy. Core tenets include empathy, reflective listening, and affirmation. MI is often used in conjunction with the Stages of Change (precontemplation, contemplation, preparation, action, maintenance), although these approaches were developed separately. Lasting change occurs when the client is ready and begins to make progressive behavioral adjustments. For more information, visit Motivational Interviewing Network of Trainers or the SAMHSA/CSAT Treatment Improvement Protocols, Chapter 3—Motivational Interviewing as a Counseling Style.

Intensive Case Management (ICM)

The primary goal of case management is to help enhance and improve a client's wellbeing and ability to function by providing and coordinating high-quality services. This EBP was designed for use with clients who have multiple, complex needs. The core functions of case management include assessment, goal setting, service coordination, discharge planning, and termination (see below for more information on the core functions). ICM provides a higher level of engagement for clients who need higher levels of support to maintain stability. Developed by using characteristics from ACT and case management, ICM is beneficial for clients living with SMI or Substance Use Disorders and co-occurring disorders, as well as those who need a high level of supportive interaction to maintain mental health, housing, or both. Characteristics of ICM include small caseloads, availability for crisis intervention, and regular, frequent, therapeutic interactions. Typically, this EBP is provided using a team-based approach. For more information view the Comparison of Assertive Community Treatment and Intensive Case Management for Patients in Rural Areas.

ICM Key Components

- Build Rapport: An interactional, interpersonal process in which the therapist/coach/case worker creates an environment of genuine warmth and empathy, which enables the client to enter a helping relationship and work toward change.
- Assessment: An ongoing process that identifies presenting problem(s) and notes client strengths, challenges, and outside supports. The depth of the assessment varies depending on client needs.
- Goal Setting: A collaborative effort between the therapist and client through which goals are set to address presenting problem(s). Goals must be specific, measurable, achievable, realistic, and time sensitive (SMART).
- Service Coordination: Assistance in accessing medical, social, educational, and other services and supports to help a client enhance his/her/their self-sufficiency and improve wellbeing.
- Termination: Termination of services is a final component in case management. Termination occurs when a client is finished with treatment/care or when a client disengages from the process. In the case of termination for noncompliance, it should only be considered in the most egregious of circumstances and they should be allowed to return to care if circumstances change.

In Summary

The interventions described above help clients with high needs who require intensive levels of care. Central to each EBP is a focus on the client—client choice coupled with voluntary, individualized services. Ensuring that client needs remain the focus of our work helps elicit positive outcomes. When coupled with EBPs implemented to fidelity, we can comfortably predict positive outcomes. This is important during this time of great stress and uncertainty, particularly among clients who have multiple vulnerabilities. For additional resources on each EBP, please visit the links embedded in the document. For equity-related resources, please visit the Disaster Response Rehousing Equity page.