

REPORT

NATIONAL
INSTITUTE
—for—
MEDICAL
RESPITE
CARE

Promising Practices: Providing Behavioral Health Care in a Medical Respite Setting

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INTRODUCTION

[Medical respite care](#) (MRC) programs, also known as recuperative care programs, offer a safe place for people experiencing homelessness (PEH) to heal from illness or injury while accessing medical care and supportive services. Consumersⁱ in these programs have complex medical and social needs that are often driven and exacerbated by underlying mental health and substance use conditions. As MRC programs strive to optimize outcomes and provide whole-person care, they are increasingly exploring innovative approaches to integrate behavioral health care into their service models. *“The term ‘behavioral health’ in this context means the promotion of mental health, resilience, and wellbeing; the treatment of mental and substance use disorders; and the support of those who experience and/or are in recovery from these conditions.”*¹

In support of programs’ efforts to meet the behavioral health needs of their consumers, the National Institute for Medical Respite Care (NIMRC) conducted listening sessions, interviews, and a review of relevant literature around behavioral health in MRC settings (a more detailed description of the activities and data that informed the development of this resource can be found in [APPENDIX A](#)). This report presents a summary of the findings and highlights promising practices in behavioral health care that are currently being implemented in MRC programs across the country. It outlines strategies and approaches that can be replicated and adapted to other programs’ unique contexts, equipping them to deliver high-quality care that is consistent with the [Standards for Medical Respite Care](#) and is responsive to the needs of PEH in their communities.

Background: Behavioral Health & Homelessness

When discussing the relationship between behavioral health conditions and homelessness, it is important to acknowledge the widespread stigmatization and misunderstanding of these conditions as personal and moral failings.^{2,3} Further, behavioral health issues are often falsely cited as the primary cause of homelessness, but this mischaracterization fails to recognize the social and structural drivers of homelessness including the cumulative impact of inequitable and harmful policy decisions, systemic racism, and a severe shortage of affordable housing.^{4,5,6,7} At the same time, behavioral health conditions do increase the risk of experiencing homelessness *and* can be created or exacerbated by the traumatic experience of homelessness.^{6,8,9}

Attempts to estimate the prevalence of behavioral health disorders among PEH have varied substantially due to differences in location, methodology, and the sub-populations studied, but a large body of evidence suggests that PEH have vastly higher rates of behavioral health conditions than the general population (please see *Table 1*). Further, seven of the ten MRC programs who participated in listening sessions for this project reported that “nearly all” of the consumers in their programs have behavioral health concerns, and the remaining three programs reported that this is true for at least half of their consumers.

ⁱ MRC programs may use different terminology in place of consumer, such as client or patient.



Table 1: Prevalence of behavioral health conditions among PEH.

<p>A recent systematic review and meta-regression analysis found the following average prevalence rates of current behavioral health disorders among PEH in high-income countries:¹⁰</p> <ul style="list-style-type: none"> • Any current mental disorder: 76.2% - (<i>versus ~21% in the U.S. general population¹¹</i>) • Schizophrenia spectrum disorders: 12.4% - (<i>versus ~0.25-0.64% in the U.S. general population¹²</i>) • Major depression: 12.6% - (<i>versus ~8.4% in the U.S. general population¹¹</i>) • Bipolar disorder: 4.1% - (<i>versus ~2.8% in the U.S. general population¹³</i>) • Alcohol use disorder: 36.7% - (<i>versus ~10.2% in the U.S. general population¹¹</i>) • Drug use disorders: 21.7% - (<i>versus ~6.6% in the U.S. general population¹¹</i>) • Personality disorders: 25.4% - (<i>versus ~9.1% in the U.S. general population¹⁴</i>)
<p>An analysis of nationally representative patient survey data from HRSA-funded health centers found that patients experiencing homelessness had higher rates of behavioral health conditions than those who were housed:¹⁵</p> <ul style="list-style-type: none"> • Depression (ever): 67.4% - (<i>versus 50.1% housed</i>) • Generalized anxiety (ever): 52.2% - (<i>versus 35.4% housed</i>) • High risk of alcohol dependence: 12.1% - (<i>versus 1.1% housed</i>) • High risk of drug dependence: 15% - (<i>versus 1.2% housed</i>) • Any injection drug use (ever): 14.3% - (<i>versus 2.9% housed</i>)
<p>A recent analysis of a large electronic health record dataset in the U.S. compared patients who were identified as experiencing homelessness (n=54,155) with a comparison group matched on age and gender (n=76,539). PEH had much higher rates of lifetime substance use conditions documented than the comparison group:¹⁶</p> <ul style="list-style-type: none"> • Amphetamines: 7.6% - (<i>versus 0.4% in the comparison group</i>) • Cocaine: 17.7% - (<i>versus 1.6% in the comparison group</i>) • Opioids: 15.2% - (<i>versus 2.0% in the comparison group</i>) • Alcohol: 42.6% - (<i>versus 8.5% in the comparison group</i>) • Cannabis: 20.2% - (<i>versus 2.8% in the comparison group</i>) • Sedatives: 3.5% - (<i>versus 0.4% in the comparison group</i>) <p>Furthermore, across a range of health care settings (excluding psychiatric facilities), patients who were identified as experiencing homelessness also had high rates of mental health conditions recorded.</p> <ul style="list-style-type: none"> • Major depressive episode: 28%-42% • Anxiety disorder: 25%-34% • Bipolar disorder: 15%-24% • Suicidal thoughts: 11%-35%
<p>A review of more than 64,000 housing prioritization surveys known as the Vulnerability Index - Service Prioritization Decision Assistance Prescreen Tool (VI-SPDAT) across 15 states found that:⁸</p> <ul style="list-style-type: none"> • 78% of unsheltered PEH and 50% of sheltered PEH self-reported having a mental health condition. • 75% of unsheltered PEH and 13% of sheltered PEH self-reported having a substance use condition.
<p>According to national data from the 2019 Point-in-Time Count (a HUD-required process in which localities collect and report the number and demographics of PEH in their communities on a single night):¹⁷</p> <ul style="list-style-type: none"> • 116,179 or 20.5% of respondents self-reported having a severe mental illness (<i>versus ~5.6% in the U.S. general population¹¹</i>).

A recent systematic review of the literature found that standardized mortality rates for PEH ranged from 8.6 to 16.1 times greater than non-homeless comparison groups¹⁸ and documented an average age of death far below that of the general population.^{18,19} Unmet behavioral health needs profoundly contribute to these premature deaths among PEH. Mortality studies conducted in Boston, San Francisco, Los Angeles, and Alameda County all found that overdoses from drugs and alcohol were the leading cause of death for PEH,^{20,21,22,23} and deaths associated with complications from chronic alcohol use (e.g., liver cirrhosis) were also significant.^{21,22,23} Several studies identified suicide as a leading cause of death among PEH,^{18,22,24} and analyses conducted in Los Angeles and Alameda County found that PEH were 7.7 and 14.1 times more likely to die by suicide than the general population, respectively.^{22,23} Notably, the risk for suicide and fatal overdose is significantly elevated following discharge from inpatient settings,^{25,26} so providing MRC after hospitalization may be particularly effective in preventing such post-discharge deaths among PEH.

In addition, physical health and behavioral health are inextricably linked. PEH have disproportionately high rates of chronic medical conditions such as heart and lung diseases, diabetes, and HIV,^{6,9} and unmanaged behavioral health symptoms can worsen these medical conditions, inhibit effective treatment, and increase risk for avoidable complications and premature mortality.^{27,28,29}

Implications for Medical Respite Care Programs

For decades, behavioral health services have been siloed and delivered in contexts that are “geographically, financially, culturally, and organizationally separate from mainstream health care.”³⁰ The enduring impacts of this separation have resulted in behavioral health workforce shortages, inadequate access to care, stigmatization, poor coordination among providers, and ongoing difficulty enforcing parity laws that require insurers to offer behavioral health benefits to the same extent as medical and surgical benefits.^{31,32,33} Within this context, MRC programs face numerous operational and financial challenges to integrating sufficient behavioral health support into their service models, and some programs may even be hesitant to accept referrals for consumers with severe behavioral health conditions. **However, we suggest that PEH with co-occurring medical and behavioral health conditions are often those most in need of MRC, and programs have an opportunity to achieve the highest impact with this vulnerable population.**

“Probably 85-90% of our folks have behavioral health concerns, and it just affects everything. And usually, those are what’s leading them to getting into a medical situation where they need medical respite – behavioral health is driving that.”
-Edward Thomas House

“Behavioral health needs, or perhaps the failure to fully respond to them or address them, have been significant barriers to the medical care of our patients... We’ve bumped into that several times now to the point where - I’m a medical clinician and - the medical issues seem to be less of a barrier than the addiction and mental health issues.” -Sojourner House & Loyola Medicine/MacNeal Hospital

Health outcomes:

PEH referred to MRC are likely to have co-occurring behavioral health and medical conditions,^{34,35,36} and there is substantial evidence that the compounding impact of these concurrent illnesses severely complicates treatment and worsens outcomes.^{27,28,29,37} These dynamics underscore the need for comprehensive and integrated medical and behavioral health services in MRC programs. Service-delivery models that integrate primary and behavioral health care are widely understood to be the most effective approach for meeting the complex needs of PEH with co-occurring conditions and optimizing health outcomes.^{38,39,40} Practical strategies for initiating and/or improving upon the delivery of integrated care within MRC settings, while simultaneously addressing key social determinants of health (e.g., housing, health literacy, transportation, social connection, etc.),^{41,42} will be discussed in this resource.

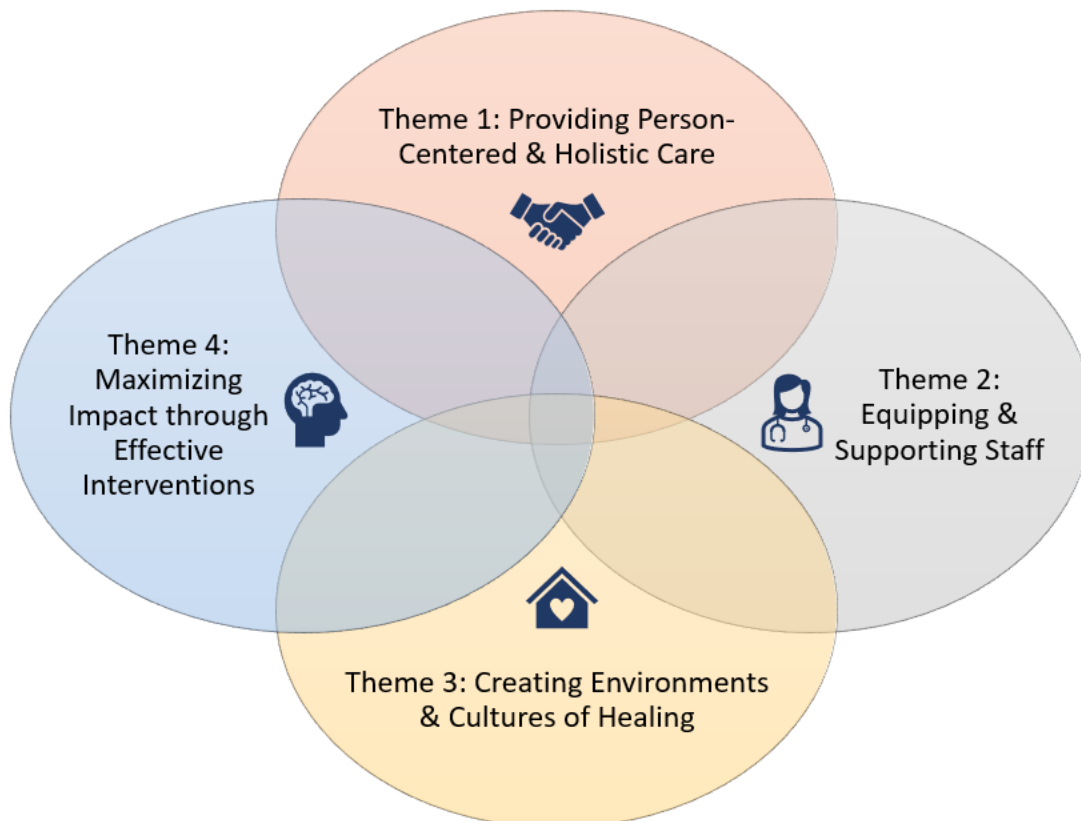
Programmatic and community outcomes:

Providing care that is responsive to the behavioral health needs of consumers in MRC is essential for programs to achieve the community-level goals that tend to be prioritized by funders and stakeholders such as hospitals, payers, public agencies, and more. Studies have shown that unmet behavioral health issues are key drivers of costly hospitalizations, readmissions, and use of emergency services.^{40,43,44,45,46} For instance, an examination of health care costs among PEH in Ontario, Canada, and found that 30% of PEH with mental illness had healthcare costs in the top 5% of all patients in the city, significantly higher than PEH without mental illness (16%).⁴³ Additionally, the South Jersey Behavioral Health Innovation Collaborative found that 82% of high-utilizing patients (n=681) who visited all of the participating health systems during a five-year period had at least one behavioral health condition, and these 681 patients accounted for nearly 30,000 hospital visits costing \$260 million, of which only \$31 million was reimbursed.⁴⁶ Improving access and facilitating connections to integrated, outpatient care in the community can significantly mitigate such avoidable hospital visits and emergency service encounters.^{38,44,47} Meeting this challenge thus represents a promising opportunity for MRC programs to demonstrate their value to funders and community stakeholders.

Additionally, research and anecdotal data from MRC providers indicate that substance use disorders are associated with early and unplanned discharges from MRC, resulting in fewer connections to community-based services and increased likelihood of returns to the hospital.^{48,49} Providing integrated care and adequate support for consumers with behavioral health conditions helps with retention and successful completion of care plans and program objectives.

PROMISING PRACTICES: BEHAVIORAL HEALTH IN MEDICAL RESPITE CARE

Promising practices that emerged from a careful analysis of the data collected in preparing this report have been organized into four broad themes. **Importantly, there is substantial overlap between these cross-cutting themes and practices.** For instance, skills and frameworks such as motivational interviewing and trauma-informed care may permeate and inform nearly every aspect of practice within multiple domains. The promising practices presented below are accompanied by supporting evidence from the literature and quotes from listening sessions/interviews. Some of the quotes throughout this report were lightly edited for brevity and clarity.



Overview & Navigationⁱⁱ:

- Theme 1: Providing Person-Centered & Holistic Care
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- Theme 2: Equipping & Supporting Staff
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 - Practice 3.3: Social activities and community-building
 - Practice 3.4: Mitigating disruptive behaviors
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 - Practice 4.1: Harm reduction
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 - Practice 4.3: Individual and group therapy
 - Practice 4.4: Incentives and Contingency Management
 - Practice 4.5: Enhancing health care engagement
 - Practice 4.6: Continuity of care post-discharge

ⁱⁱ Clicking on an item above will direct the reader to the corresponding theme or practice.

THEME 1: PROVIDING PERSON-CENTERED & HOLISTIC CARE

Providing person-centered and holistic care emerged as a prominent theme in listening sessions and interviews with MRC programs. Person-centered care involves collaboration between consumers and providers to identify needs, develop goals, and implement treatment plans. Providers strive to “meet people where they are” and holistically consider their interconnected social, medical, and behavioral health needs. They respect and prioritize consumers’ values, preferences, experiences, strengths, and self-determination throughout this process.

Practice 1.1: Universal behavioral health screening

MRC program representatives who participated in listening sessions and interviews (now referred to as “programs”) widely reported that they incorporate universal screening for behavioral health conditions into initial assessments,^{50,51} meaning that all consumers entering the MRC program are screened regardless of their primary reason for referral. Some programs use standardized assessment tools such as the Patient Health Questionnaire (PHQ-9) for depression, the Generalized Anxiety Disorder 7-Item Scale (GAD-7), and then if indicated, the Ask Suicide-Screening Questions (ASQ). Other programs include behavioral health components in their agency-specific intake processes and/or biopsychosocial assessments.

Programs noted that detecting behavioral health symptoms and understanding consumers’ substance use patterns early in the MRC stay is vital for developing effective care plans, coordinating services between multiple providers and staff, educating and empowering consumers, and optimizing health outcomes. Furthermore, programs have learned that normalizing these screenings and presenting them as a “built-in” component of the program reduces stigma and helps overcome hesitancy to discuss behavioral health concerns.

“Everyone gets the same assessments across the board. We explain to every resident that comes in that ‘we do these for everyone; it’s just to help us understand where you are and if there are any other services you might need.’ Based on how they score on those assessments - if there’s increased depression, anxiety, paranoia, any of those things - we offer them services. Sometimes they decline; sometimes they’re willing to look at it a little further; but it’s all about meeting them where they are when they enter our program.” -Joseph’s Home

Practice 1.2: Integrated and interdisciplinary care

Echoing the research presented in the introduction to this report, MRC programs emphasized the value of providing integrated medical and behavioral health care to consumers. They cited numerous logistical, clinical, and organizational considerations informing their commitment to an integrated model. These efforts align with the framework articulated by the SAMHSA-HRSA Center for Integrated Health Solutions: *“Building and sustaining integrated care means all facets of the organization must reflect the values of whole health, collaborative care, and the understanding that successful clinical outcomes are everyone’s responsibility.”*⁵²

MRC programs incorporate a variety of behavioral health clinicians into their treatment teams, including Clinical Social Workers, Licensed Professional Counselors, Psychologists, Psychiatrists, Psychiatric Nurse Practitioners, Licensed Alcohol and Drug Counselors, Peer Providers, and others. They employ different models for integrating these clinicians based on the varying resources and structure of each program. Some have behavioral health clinicians embedded within the program while others bring these services onsite through their larger organization (as with HRSA-funded health centers) or through a formalized agreement with a partnering agency. For instance, Firehouse Respite Program described a robust partnership with University of Alabama at Birmingham Medicine to provide an onsite day-treatment program five days per-week that offers access to therapy, psychiatry, primary and specialty medical care, medication-assisted treatment (see Practice 4.2), and housing support.

MRC programs described several facilitators for effectively integrating behavioral health care into their service-delivery model. First, programs can create streamlined processes to ensure that timely consultations with a behavioral health provider are available when needed. Second, regularly scheduled, interdisciplinary team meetings facilitate productive communication and coordination between providers and support the development and implementation of “shared treatment plans.” Third, programs leverage electronic health records (EHR) or other client-management software to document goals and progress, make appropriate referrals (both internally and externally), coordinate care, and ensure quality and accountability.³⁹ Of note, programs should be cognizant of HIPAA guidelines specific to the protection of psychotherapy notes, which are treated differently than other personal health information.⁵³ Multidisciplinary collaboration and enrichment will be discussed further in Practice 2.4.

[The MRC program] “...has an integrated medical and behavioral health component which prevents, in many cases, patients having to go to carve-out mental health services... One of the things we’ve noticed that patients struggle with is that process of going through the sequence of steps to get connected to a community provider versus working inhouse with the respite behavioral health provider... Especially those who aren’t able to articulate their symptomology, how that impacts their functioning, and even navigate the system to get help.”
**-Peninsula Healthcare Connections-
 New Directions & Santa Clara County
 Medical Respite Program**

Practice 1.3: Being responsive to consumers’ readiness-level

MRC programs noted that many consumers presenting with behavioral health needs initially decline behavioral health services because of stigma, past trauma, mistrust, more immediate priorities associated with surviving homelessness, and other reasons. For example, PEH may use substances in an effort to self-medicate and cope with untreated mental illness and the trauma of homelessness. Programs emphasized the importance of providing flexible, individualized, and empathetic care for consumers while educating and equipping them to make informed decisions about their health.

This responsive approach aligns with recommendations from SAMHSA and other research indicating that understanding the stages of change - precontemplation, contemplation, planning, action,

maintenance, (and relapse) – helps providers to meet consumers where they are and develop appropriate and effective treatment plans.⁵⁴ Incrementally building trust and engagement during the course of a MRC stay requires time and patience. Care plans should be tailored to consumers' current readiness-level and should be dynamically adapted as readiness changes. Motivational interviewing techniques and peer support services were both identified as important tools for navigating this process, and these interventions will be discussed in subsequent sections.

“Very few people take it up on the first try. So, we generally try, as we get to know them, to ask in different ways and have different people ask them. Like if it’s talk-therapy, asking, ‘Hey, would it help you to have someone to talk to about some of this?’”

-LifeLong Adeline Recuperative Care

Illustrating this flexible approach, Sojourner House & Loyola Medicine/MacNeal Hospital shared a story of a consumer who was referred, while a hospital inpatient, to attend an intensive outpatient treatment program (IOP) offered by the hospital post-discharge. Upon entering the MRC program, however, he chose not to return to the hospital for IOP. MRC staff explored alternatives and identified a support group offered through a local National Alliance for Mental Illness (NAMI) chapter that was acceptable to the consumer. *“This was clearly something he needed... and while he was against returning to the hospital, he was willing to go to a community program, NAMI, to get – probably not the same – but similar support. And that worked out fairly well for that one patient.”*

Practice 1.4: Peer Support

Programs emphatically described peers as invaluable team members in MRC. They noted that peers are often able to “engage in a relational conversation” that serves to “gain trust and break down walls” due to their shared experience. Peers can help to dispel harmful myths about behavioral health conditions, motivate ambivalent consumers toward positive change, link consumers to appropriate resources, coordinate care, advocate to ensure that consumers' voices are heard, and inspire hope that recovery is possible.⁵⁵

Peer support is provided by individuals who have common life experiences with the people they are serving and have a unique capacity to help based on a shared affiliation and a deep understanding of particular experiences.^{56,57} Peer providers may also be identified as: recovery coaches, peer support specialists, peer advocates, patient navigators, and more.

Importantly, two programs emphasized that strong supervision is essential to help peer specialists succeed and thrive. The personal and relational nature of peer-work can

“Our peers really focus on continued engagement and rapport – helping to keep people linked into that integrated care team. I love peers [laughs]; I think that peer work and case management are some of our most undervalued and under-utilized positions... After people discharge, that ability to connect people to services and keep them in services – that type of work is what keeps people out of the hospital. It’s not that we have bad doctors – there are great doctors in all of our cities. It’s these care coordination pieces that are really the missing element of the care for unhoused patients... Peers are really invaluable to what we do.”

-Colorado Coalition for the Homeless

involve elevated risks for re-traumatization and burnout as well boundary issues between consumers and peers. However, adequate training, education, and supervisory support can mitigate these risks.

“The recovery coach has been designated as the person who can relate to the patient in a different manner. So, they are actually engaging with those who are actively using... We don’t want to discharge [these patients]; we want to put systems in place to help them stay here and receive services. And that has proven to be very helpful for, not only the patients, but also the whole staff.” -Barbara McInnis House

Practice 1.5: Cultural humility and culturally-responsive care

Programs identified cultural humility as a key element for successfully meeting the needs of consumers in MRC and observed that culturally-responsive approaches can improve engagement, retention, and outcomes.⁵⁸ Providing culturally-responsive and inclusive care involves attending to the social, cultural, spiritual, and linguistic needs of consumers and tailoring services accordingly.⁵⁹ It requires providers to adopt an attitude of humility and openness, along with an awareness of the ways in which their own cultural values, norms, and biases can impact the helping relationship.⁶⁰ Notably, a lens of cultural humility was evident throughout the discussions, indicating that cultural considerations should be given careful attention when implementing all of the practices outlined in this report.

*“We want to make sure that we aren’t just celebrating who we do really well with, but that we are taking the time to say, ‘Who are we missing, and what are the themes of that, and how do we make sure that we are creating spaces that can accommodate people from different backgrounds?’”
-Hennepin County Health Care for the Homeless*

Peninsula Healthcare Connections-New Directions & Santa Clara County Medical Respite Program provided a compelling example of cultural humility and inclusion in practice. They described steps that they have taken to offer consumers a flexible menu of recovery support options in the community, based on individual values, beliefs, and preferences. *“There are often factors around culture and spirituality that, if you really peel the onion during that comprehensive assessment, you’ll understand that someone might have a cultural viewpoint that isn’t a good match with a 12-step program, where there is a belief in a higher-power and actual verbiage of ‘God.’ So, when we would talk to patients and they would say ‘I’m not going there; I don’t believe in God,’” that’s where the creative, outside-the-box thinking came in... We now try to look at culturally-competent forums for people to go to for support when dealing with addiction. That could span anything from classic 12-step programs to a SMART recovery model, or there is a Recovery Café model in Santa Clara... and then also other non-secular approaches to recovery including Recovery Dharma and Refuge Recovery that takes more of a mindfulness, Buddhist approach. I think that’s helped people who have gone through the system and been told the classic, linear model of treatment is the only way.”*

THEME 2: EQUIPPING & SUPPORTING STAFF

MRC programs emphasized that they cannot meet their goals of providing high-quality, responsive, and compassionate care without first attending to the needs of their staff. Staff must be adequately trained and equipped with the evidence-based skills and knowledge required to meet the complex behavioral health needs of PEH. Further, programs described a direct connection between the safety and wellbeing of staff and the quality of care for consumers. A collaborative, collegial, and supportive approach is essential for MRC programs to thrive.

Practice 2.1: Staff training, skills, and knowledge

Almost universally, MRC programs reported that they train staff in trauma-informed care, Motivational Interviewing, and verbal de-escalation during the onboarding process, and these skills are revisited on an ongoing basis. Many programs referenced two specific training modalities/approaches: Crisis Prevention Institute⁶¹ and Mental Health First Aid⁶². Some programs also reported providing education in the principles of harm reduction, an accepting, non-coercive approach that aims to minimize the negative impacts of substance use while making incremental, positive changes. Notably, programs often train *all* staff members in these essential skills, including administrative and support staff, recognizing that these are organizational and cultural issues that should inform each facet of the program. Several of the skills and concepts introduced here will be discussed greater detail shortly.

Programs deliver training and education to their staff in a variety of ways. Some hire outside instructors and utilize standardized training programs, while others leverage relationships with community partners such as local hospital systems and public health departments for training. Still others conduct customized, internal trainings led by behavioral health clinicians within their own organization. One program also described a professional development stipend allocated for each staff member to use flexibly for self-identified training priorities (in collaboration with supervisors).

Importantly, MRC program staff should also receive foundational education around recognizing and understanding common mental health symptoms and how these can impact engagement in services. For instance, consumers with mental health symptoms such as low motivation or initiation may be mislabeled and perceived as “non-compliant” or “unmotivated,” resulting in frustration for staff and punitive responses. However, these are actually symptoms of clinical diagnoses in which increased support and adaptive strategies from providers and staff can increase consumers’ participation in care. Similarly, the ability to recognize and monitor potential side effects from behavioral health medications allows staff and providers to more accurately identify barriers to recovery and help consumers develop strategies for success. Other symptoms such as hallucinations or delusions may be perceived as unsafe, threatening, or inappropriate in MRC settings, but in fact, many individuals compensate, maintain social relationships, and manage their daily lives despite the presence of such symptoms. Educating staff about psychosis and related symptomology can reduce stigma and discomfort and improve quality of care.

Practice 2.2: Motivational Interviewing skills

MRC programs cited Motivational Interviewing (MI) skills as invaluable assets for effectively engaging consumers with behavioral health issues, helping them to mobilize their internal strengths and make positive changes.⁶³ MI is a collaborative and person-centered conversational style aimed at eliciting personal reasons for and commitment to change.^{64,65} In this approach, providers seek to address ambivalence about change in an atmosphere of acceptance and compassion, while resisting the “righting reflex,” or tendency to attempt to *fix* consumers’ problems for them.⁶⁴ The table below outlines core elements of MI including the spirit behind this approach, the process, and some of the techniques involved.

Table 2: Core Elements of MI^{64,65}

The MI Spirit	The Four Processes of MI	MI Conversational Skills: OARS ⁱⁱⁱ
<ul style="list-style-type: none"> Partnership Acceptance Compassion Evocation 	<ul style="list-style-type: none"> Engaging Focusing Evoking Planning 	<ul style="list-style-type: none"> Open questions Affirmations Reflections Summarizing

Importantly, MI applies to a broad range of challenges and conditions and can be learned and practiced by all staff members in the program, not just clinicians and counselors. One program also noted that, in order to embody the accepting and strengths-focused spirit of MI, it is important that staff are trained to use person-first language that counteracts stigma.⁶⁰ For example, saying *people experiencing homelessness* rather than *the homeless*, or *person who uses substances* rather than *addict* or *drug abuser*.

Practice 2.3: Physical and psychological safety

Programs acknowledged the risks for experiencing trauma (both direct and secondary) and the potential for dangerous or violent situations in MRC settings. To ameliorate these risks and the impact on staff wellbeing, programs have developed a variety of strategies and policies intended to cultivate a safe and trauma-informed workplace.⁶⁶

Two programs described utilizing Behavioral Health Technicians (terminology varies) for milieu management^{iv} activities and daily programming. These staff are trained to recognize and intervene in potentially hazardous situations before they escalate. The programs reported that these specialist staff are better equipped to manage the complex safety issues that arise in MRC than security personnel.

ⁱⁱⁱ A fifth, commonly cited MI skill/technique is *information exchange*: sharing information, advice, or concerns with consumers after obtaining permission.

^{iv} Milieu management, or milieu therapy, refers to cultivating a safe and structured environment in which patients can interact positively with others and practice psychosocial skills.

Additionally, multiple programs have formed Safety Committees that help to debrief critical incidents, provide staff support, and conduct ongoing quality improvement around safety policies/procedures. Finally, programs have created various emotional and psychological support opportunities for staff. These may include easily accessible counselling services and/or other wellness and self-care opportunities.

“We recognize that our staff is also traumatized by the events and the experiences that we are sharing with our patients. And we have trauma support exclusively for staff. So, twice a week, we have a trauma specialist just sitting in a conference room waiting for staff to come in and talk, and that has been very helpful for staff. And the end result of that is providing a better quality of care for our patients.”

-Barbara McInnis House

“We spend a lot of time with situations that were handled ok but maybe not ideally. We all group-process it and break it down and do some role-playing and really try to be proactive... And that’s been very helpful because people need to get it off their chest if they are scared or confused...”

-Firehouse Respite Program

Practice 2.4: Multidisciplinary collaboration

Expanding on the integrated care framework described in Practice 1.2, MRC programs highlighted the value of multidisciplinary collaboration for supporting professional development, satisfaction, and efficacy. Multidisciplinary teams have the potential to “maximize collective intelligence” by aggregating diverse knowledge and expertise,⁶⁷ while also enhancing and enriching staff members’ professional experience.³⁹ Programs reported, for example, that behavioral health clinicians provide essential education for care teams about specific behavioral health conditions, symptomology, and considerations around medication. These behavioral health staff also support safety, overdose, and relapse prevention planning, notify providers about signs of potential decompensation, and make appropriate referrals to community-based treatment programs, as indicated. In one program, an onsite Occupational Therapist conducts cognitive assessments with consumers showing signs of impairment and then provides other staff members with communication strategies tailored to these consumers’ unique needs.

Several programs have formed collaborative relationships with external, partnering providers. For example, Circle the City Medical Respite Program (operated by a HRSA-funded health center) and Edward Thomas House (operated in partnership with a hospital) both reported that they provide access to visiting psychiatrists who hold office hours once per week. Another program described consulting with county public health nurses and pharmacists for consumers in need of additional support. Programs take great care to protect such relationships by following established referral protocols, creating a shared understanding of roles and responsibilities, and keeping lines of communication open.

THEME 3: CREATING ENVIRONMENTS & CULTURES OF HEALING

When discussing strategies for meeting the behavioral health needs of PEH, programs placed at least as much emphasis on the interpersonal, environmental, and community components of MRC as they placed on the quality of clinical services. Consumers' experience during daily programming and the general milieu significantly impacts care and may be a key predictor of treatment engagement and outcomes. Accordingly, programs put enormous thought and effort into creating environments and cultures of healing.

Practice 3.1: Trauma-informed organizations

MRC programs described myriad strategies and quality improvement efforts to move toward trauma-informed care. "Being a trauma-informed organization is a practice transformation which recognizes the trauma of consumers, staff, and the community, and creates an organizational structure that avoids re-traumatization and encourages healing."⁶⁸ There are numerous resources to assist organizations in this practice transformation, and six guiding principles of trauma-informed care have been widely recognized:^{68,69}

1. Safety
2. Trustworthiness & transparency
3. Peer support
4. Collaboration & mutuality
5. Empowerment & choice
6. Cultural, historical, & gender issues

Programs emphasized the importance of reducing barriers by maximizing consumer choice, voice, and autonomy wherever possible. For example, some programs create opportunities for consumers to share feedback via community meetings and anonymous suggestion boxes. Other considerations such as providing gender affirming care,⁷⁰ assessing and capitalizing on consumers' strengths, and making respectful accommodations for consumers' personal property were also noted. Guiding principles such as peer support, safety, and cultural humility are explicitly discussed elsewhere in this resource.

*[A trauma-informed approach]
"...allows us to better understand where the patients are coming from and how these traumatic experiences have affected a lot of the ways that they engage and communicate their frustrations, or even their day-to-day situations."
-Barbara McLinnis House*

MRC programs' emphasis on trauma-informed care starts with an understanding of the prevalence of past trauma among PEH and that homelessness is itself a traumatizing experience.⁷¹ In fact, in a 2019 analysis of 64,000 housing prioritization surveys of PEH across 15 states, 46% of unsheltered respondents and 34% of sheltered respondents reported that an experience of abuse and/or trauma had contributed to their current episode of homelessness.⁸

Practice 3.2: Designing the physical space

Programs shared that the physical space in MRC facilities is a critical element in fostering a healing and trauma-informed environment. Programs described various efforts to create spaces that do not feel “institutional,” considering that many PEH with behavioral health conditions have had traumatic experiences in institutional settings such as jails and inpatient psychiatric units. Strategies programs have implemented include decorating the facility with personal artwork, avoiding harsh lighting (e.g., using soft or natural lighting versus florescent), incorporating plants/gardens, and providing comfortable, outdoor sitting areas for fresh air, socializing, and/or smoking. Several programs reported that they provide designated, private spaces for consumers to separate themselves from the noise and activity of the common areas as needed. At least two behavioral health clinicians reported intentionally designing their offices to include soothing scents, sounds, and lighting and allowing consumers to access these spaces to relax and decompress.

Interestingly, programs have learned that ideal bedroom/sleeping arrangements may vary substantially between different consumers. For many PEH, a private room will provide a sense of safety and an opportunity to “slow down, take a breath, and see things a bit differently.” However, programs have observed that some consumers with behavioral health conditions, particularly those with positive symptoms of psychosis (e.g., hallucinations and delusions), may decompensate if isolated in a private room without the support and stimuli of shared living spaces. When facilities and resources allow, it may be beneficial to have multiple, flexible options for room arrangements so that consumers can be placed in settings that best meet their individual needs.

“Being in a homeless shelter is so busy and so loud... So, trying to carve out those little spaces where they can go and be by themselves. Our social worker has been really good about making her office less clinical - and she does, like, the scents, and calming music, and a little waterfall. And the guys know that they can go there if they need a space to chill out and relax.”

-Firehouse Respite Program

“At Joseph’s Home, the hallways are lined with paintings that the men have done for the past 20-years in the various art-therapy programs.” **-Joseph’s Home**

Practice 3.3: Social activities and community-building

Programs described a range of activities and daily programming aimed at strengthening social connections, providing opportunities for creativity, and building a shared community. Several programs offer art and music therapy, crafting activities, and communal games such as bingo. Some programs have gardens where consumers can help care for plants, and it was noted that activities such as gardening, cleaning, and decorating can create a valuable sense of ownership and investment. Still other programs offer optional recovery support groups and religious services for those who wish to participate.

Dedicated volunteers are often utilized to support the activities described above, and one program has a Mental Health Counselor on staff who facilitates such therapeutic, recreational group activities. Finally, many programs hold regular town hall meetings where consumers are encouraged to have an active voice and share challenges, successes, concerns, and encouragement with staff and their peers. These meetings and other group activities can contribute to a sense of belonging and create important opportunities for mutual, peer-to-peer support.

[It's important] "...to have groups and build a community where folks feel like they are part of a larger social setting than just themselves. If people can build those strong community ties with their neighbors around them, they are more inclined to follow up with care, sometimes, and be successful because there is almost some accountability built-in..." -Colorado Coalition for the Homeless

"Our approach is to create a culture of trust, healing, dignity, respect. So, we have town hall meetings on a regular basis where both patients and staff participate. We're building this community. And we strongly encourage patients' input because we want to hear from them... And that usually is so positive; there is a commitment to everyone being involved in the creation of this culture." -Barbara McInnis House

Practice 3.4: Mitigating disruptive behaviors

Problematic behaviors associated with behavioral health conditions can undermine recovery in MRC, cause significant disruptions to MRC programming, and impact the safety and treatment of other consumers. Programs have implemented numerous strategies to mitigate such behaviors and ensure safety while maintaining a commitment to admitting and retaining consumers with complex behavioral health needs.

Programs emphasized the importance of providing a thorough orientation for consumers, clearly articulating expectations, and establishing open and honest communication during the intake process. Firehouse Respite Program described proactively developing and documenting "de-escalation plans" so that staff "...can have what soothes and relaxes them, who we need to call... We take care of that [planning] right at the get-go when we do the universal health screening to kind of mitigate some of those crisis situations."

As discussed in Practice 2.3, some programs designate Behavioral Health Technicians or Case Managers who specialize in building rapport and trust with consumers, monitoring the milieu, and intervening before situations escalate. Notably, two programs reported that there may

"When addressing behavioral health needs, or behavioral issues, those are team decisions where we really talk through the pros and cons. And I've seen our staff's muscles get strengthened over the years in those ways; and being more adaptive and flexible with creative ways to address those issue. So, it's a lot of meetings [laughs]."

-Edward Thomas House

be value in maintaining separate, designated roles between clinicians (e.g., therapists/counselors) and the staff who assist with milieu management and conflict resolution. Distinguishing between these different roles can help to preserve the therapeutic relationship between the clinician and consumer.

Despite efforts to prevent escalation and disruptions, problematic and dangerous situations do occur in MRC settings. Programs often respond by creating individualized behavior agreements (terminology may vary) with consumers who are struggling. Care teams typically develop these behavior agreements collaboratively with input from multiple team members as well as the consumer. Barbara McInnis House has formed a designated team of staff members to review such incidents and determine the appropriate response. They utilize a standardized rubric during this process in an effort to prevent bias and support equitable decision-making. Programs reported that they often tailor their responses to disruptive behavior based on the severity of the consumer's medical needs, avoiding administrative discharges whenever possible, but utilizing them as a last resort.

THEME 4: MAXIMIZING IMPACT THROUGH EFFECTIVE INTERVENTIONS

This final theme explores practices aimed at minimizing harm associated with behavioral health conditions, meeting consumers' most pressing health care needs, and equipping consumers with tools to access and sustain ongoing services beyond their stay in MRC. Programs seek to capitalize on the limited time that consumers spend in MRC by strategically focusing on high-impact interventions with a strong base of evidence behind them.

Practice 4.1: Harm reduction

Several programs reported that, in MRC settings, harm reduction principles and techniques are essential for (1) ensuring that programs are accessible and do not exclude those who may need MRC most; and (2) retaining consumers who use substances so that they can receive medical care and supportive services. Harm reduction encompasses various practices aimed at minimizing the health and social impacts associated with substance use while focusing on incremental, positive changes. Consistent with the person-centered philosophy discussed in Theme One, harm reduction programs offer services without judgement, coercion, or requiring that people stop using substances as a precondition for support.^{72,73} Such approaches have proven to be effective in reducing fatal overdoses, acute life-threatening infections associated with unsafe injection, and transmission of chronic diseases like HIV and Hepatitis C.^{74,75,76} Importantly, programs also noted that a harm reduction lens does not attempt to trivialize or ignore the real and tragic harms associated with substance use, and it is not in conflict with sobriety or cessation when consumers choose such goals.

MRC programs taking a harm reduction approach often provide consumers with various forms of health education and supplies (e.g., the overdose reversal medication naloxone) to promote safety. Generally, the programs interviewed for this report do not permit consumers to use substances on

the premises, but intoxication/substance use is not considered a reason for administrative discharge. Programs acknowledged the tension between employing this approach and maintaining a safe and healthy community, but they strive to achieve a balance that helps consumers using substances to complete their MRC treatment plans. *“As a harm-reduction environment, we’re not going to discharge someone for using, but I also have to be cognizant that it might trigger someone else into use. So, it’s kind of this fine balance of managing the needs of a whole group and the needs of individuals, as well. And that can be a real challenge.”* – Colorado Coalition for the Homeless.

Finally, Edward Thomas House emphasized the importance of having a robust “over-sedation protocol” in place to provide staff with the guidance and support needed to detect and reverse overdoses, also acknowledging how distressing such situations can be. They conduct regular safety rounds, train staff in naloxone administration, and have a protocol with clearly established indicators (e.g., oxygen saturation) to guide decision-making.

“We put it on the table right away, like, ‘you are able to use while you stay with us,’ and that really opens the door for some honest conversations. I would say that substance use is probably the primary reason that people don’t engage in nursing care, so we really work around strategies to make that happen... They aren’t able to use onsite, but if they are caught using onsite, that would be a behavioral plan conversation rather than a ‘you’re going to be discharged’ conversation. Just helping folks to manage their substance use while they’re staying with us. And of course, we would love to connect folks with long-term treatment if they are interested, but I would say that most of our folks are not in that spot.” -**Edward Thomas House**

Practice 4.2: Medication-assisted treatment (MAT)

MRC programs reported that medication-assisted treatment (MAT) is crucial in managing withdrawal and retaining consumers who would otherwise leave the program early, preventing them from completing their plan of care and placing them at high-risk for poor outcomes. MAT is an evidence-based approach that uses medications in combination with counseling and behavioral therapies to provide holistic care for opioid and alcohol use disorders.⁷⁷ It is the most effective intervention for treating opioid use disorder and has been shown to reduce mortality, increase treatment retention, and reduce transmission of chronic diseases and other adverse outcomes associated with injection drug use.^{78,79,80,81} Of note, MAT is just as effective for PEH as for those who are housed,⁸² and it is widely used by Health Care for the Homeless health centers across the United States.⁸³

Programs described various pathways for providing MAT to their consumers. Some programs, especially those operated by HRSA-funded health centers, have access to MAT prescribers within their organizations. Others form innovative partnerships to facilitate connections and coordinate care with community-based treatment programs that can offer MAT to consumers, as indicated. Edward Thomas House, for example, has an agreement with a local methadone clinic to deliver methadone at the MRC program location (*“...that has been really amazing to offer that onsite for folks”*). Additionally, the Santa Clara County Medical Respite Program offers Vivitrol injections coupled with recovery support services for consumers seeking recovery from alcohol use disorders.

Programs discussed the use of the following medications:⁸⁴

- Buprenorphine, typically with naloxone (e.g., Suboxone) - opioid partial agonist
- Methadone - opioid agonist
- Naltrexone, extended-release via intramuscular injection (Vivitrol) - opioid antagonist
 - used in the treatment of alcohol use disorders as well as opioids

Practice 4.3: Individual and group therapy

MRC programs identified appropriate and responsive therapeutic interventions as important components in meeting the complex behavioral health needs of consumers and described an array of approaches to providing such services. Some programs noted that, due to the short-term nature of MRC, behavioral health clinicians typically focus on brief interventions, psychoeducation, motivational interviewing, and developing coping skills (e.g., mindfulness exercises, emotion regulation/stress management, and relapse prevention plans). Other programs utilize qualified therapists and counsellors available within their organizations to provide various forms of psychotherapy (e.g., Cognitive Behavior Therapies), and ideally, arrange for ongoing treatment beyond the MRC stay. Multiple programs reported long wait-lists and other barriers to accessing therapy in the community, so providing these services in-house can be invaluable.

LifeLong Adeline Recuperative Care, for example, has leveraged a SAMHSA grant to offer access to a Licensed Marriage and Family Therapist while consumers are in the program. Two other programs reported that Licensed Alcohol and Drug Counsellors (LADCs) and/or peer recovery specialists facilitate support groups and accompany consumers to intensive outpatient treatment programs, with LADCs also providing individual counselling. Additional examples and considerations can be found throughout this resource (e.g., Practice 1.2).

Practice 4.4: Incentives and Contingency Management




Some MRC programs utilize Contingency Management (CM) as a tool for increasing desired behaviors by providing immediate reinforcing consequences (in the form of incentives) when target behaviors occur, and withholding those incentives when target behaviors do not occur.⁸⁵ CM has been shown to be the most effective treatment approach for stimulant use disorders (e.g., cocaine and amphetamines), particularly when combined with other interventions such as Cognitive Behavioral Therapies and community reinforcement.^{85,86,87,88}

Edward Thomas House described implementing an incentive program consistent with CM in which consumers receive stamps for positive behaviors like attending medical appointments. At the end of each week, there is a drawing where consumers can redeem these stamps for small prizes such as snacks, notebooks, flashlights, and other tokens. The staff have observed significant benefits from this incentive program, and consumers are enthusiastic about participating.

MRC programs considering CM should be aware of any monetary limitations set by Centers for Medicare and Medicaid Services, state health programs, or other regulatory entities. However, such concerns can be easily avoided by using non-monetary tokens and prizes as described above.

Practice 4.5: Enhancing health care engagement

Health education and support provided in MRC can build trust and enhance consumers' ability to complete defined treatment plans, navigate medical and behavioral health care systems, and independently manage their health. Increasing consumers' motivation and confidence to engage in health care services, both during the MRC stay and after returning to the community, may have an important and enduring impact.³⁴ The three examples below illustrate various pathways for enhancing health care engagement.

	MRC can serve as an ideal setting to support the successful completion of urgent, time-sensitive courses of treatment that would not be feasible in a shelter, street, or encampment. For instance, four programs reported that they are able to support PEH in need of outpatient parenteral antimicrobial therapy (OPAT), or the administration of intravenous antibiotics in an outpatient setting. In the absence of a safe discharge plan, PEH with complex infections tend to remain hospitalized for the duration their IV antibiotic treatment, especially if they have a history of injection drug use. ⁸⁹ MRC programs may be uniquely suited to meet the needs of this vulnerable population outside of the hospital, utilizing harm reduction practices, risk mitigation protocols, and other supportive strategies. In a 2016 study, 64% of consumers referred to Edward Thomas House for OPAT successfully completed their course of treatment, and the resulting cost savings for the hospital were estimated at \$25,000 per episode of OPAT. ⁸⁹
	Hennepin County Health Care for the Homeless discussed the value of teaching consumers how to take full advantage of their Medicaid benefits to access care, including scheduling transportation to appointments. <i>"We're lucky that we have Medicaid-expansion and also transportation benefits with the insurance. So, it's a good time, when people are in respite, to teach them how to use those benefits and help them get into the routine of going to those appointments and accessing other supportive services..."</i>
	Programs described various approaches to providing consumers with medication support and education, largely based on staffing capacity. ⁹⁰ Strategies range from offering as-needed consultation with nurses and providers to more intensive provider-supported medication management, such as filling weekly pill boxes for all consumers and/or nursing staff dispensing medications. Despite these differences, each program reported that their goal is to help consumers move along a continuum toward increasing independence with their medications.

Practice 4.6: Continuity of care post-discharge

Programs reported that planning for continuity of care in the community should begin early in the MRC stay. They emphasized the importance of facilitating "warm handoffs" to outpatient providers so that consumers can continue to access the services they need post-MRC. Edward Thomas House has a designated case manager whose primary role is to maintain contact with consumers in need of additional support after discharging from the MRC program, helping them to stay engaged with

services in the community. Barbara McInnis House has developed robust relationships with residential substance use treatment programs and has a treatment specialist on-staff to facilitate referrals and coordinate care with these programs, ensuring that consumers can access appropriate levels of care that align with their recovery goals.

MRC programs formally affiliated with HRSA-funded health centers or hospital systems reported that they can access their broader organizations' electronic health records (EHR) to keep track of consumers' health outcomes and service utilization. Such EHR monitoring allows them to follow-up and reconnect with consumers when needed (e.g., if they return to the hospital). Further, local Homeless Management Information Systems (HMIS) and Coordinated Entry (CE) are invaluable tools for maintaining or re-establishing connections with former consumers. Importantly, two programs noted that they commonly see consumers make post-discharge progress because of seeds initially planted during the MRC stay.

"When they move out, we follow them as what we call 'alumni'. We use our peer recovery supporters to work with them in the community and engage them when they're in housing to follow-up with some of those treatment providers. And we've found, actually, that some of our alumni are more likely to engage with behavioral health services that we connected them to while in the program once they're living on their own - when they're in their own housing and they're settled... So, continuing that connection and maintaining that link for them has been really beneficial." -Joseph's Home

ADDITIONAL CHALLENGES & CONSIDERATIONS

The promising practices described above provide a snapshot of MRC programs' current efforts to meet the behavioral health needs of their consumers, but there are broad, systemic issues at play that create significant obstacles to success. The structural barriers outlined below were readily evident throughout conversations with MRC programs and profoundly impact their ability to assist consumers in achieving health and wellbeing. Though these challenges and considerations extend beyond the scope of this paper, they warrant ongoing discussion and future exploration.

Financing behavioral health services in MRC:

As this report has demonstrated, providing effective behavioral health care within medical respite settings requires a wide range of comprehensive services and supports that typically do not generate Medicaid or other insurance reimbursement. Without a centralized funding mechanism for building out and sustaining such services and supports, MRC programs must creatively braid together multiple (often time-limited) grants, contracts, and other partnerships to finance much-needed behavioral health capacity.

Of the MRC programs participating in this project, HRSA-funded health center billing of Medicaid/Medicare was the most common source for defraying the cost of providing behavioral

health services, followed by contracts and grants from local government entities. Some programs have secured other public (e.g., state-based opioid response or SAMHSA) and private (e.g., local health system) funding for this work. Finally, others must develop formal partnerships and coordinate care with community-based agencies to provide necessary behavioral health care.

“It’s hard to marry all of those needs together with limited resources – either through grants, or just the way our billing structures are set up don’t usually fund communal teaching or community engagement and support... So, it can be kind of challenging to give our folks what they need.” -Colorado Coalition for the Homeless

Accessing higher levels of care:

PEH with behavioral health conditions commonly have co-occurring functional and cognitive impairments that require a higher level of care than MRC programs can safely provide, and they tend to experience these issues at younger ages than the general population.^{6,91} Unfortunately, such PEH are often excluded from more appropriate levels of care (e.g., skilled nursing facilities) due to systemic barriers including stigma/discrimination related to behavioral health, poverty, and insurance status, as well as rigid approaches to care that are incompatible with the unique needs of this vulnerable population.^{91,92,93} As a result of these gaps in the health services continuum, MRC programs are left to navigate ethical dilemmas and try their best to support consumers whose complex needs lie beyond the programs’ scope of services.⁹¹

Relatedly, some MRC programs reported that consumers presenting with acute psychiatric needs as their primary condition could be most effectively served in crisis stabilization programs (when such programs exist in the community). However, these psychiatric stabilization programs are often unable to accept consumers with concurrent medical needs (e.g., wound care), and as a result, MRC programs are left as the only viable option. It was suggested that improving coordination between programs and increasing the capacity of psychiatric stabilization programs to provide light medical care could facilitate more appropriate placements and optimize limited community resources.

“We’ve been talking about how to effectively support people who are no longer able to make decisions for themselves, whether that’s due to a mental health issue or maybe secondary to physical health or memory issues - we know this population is aging - So really, just trying to figure out how to navigate those difficult situations in a way that provides dignity to the client and has a good ethical background, and really with the goal of getting people into a safe space.” -Hennepin County Health Care for the Homeless

Housing for health and mental wellbeing:

Even high-quality, well-coordinated behavioral health care can only be marginally effective in the absence of a safe and dignified place to live. Without access to housing, no residential treatment program, therapeutic intervention, or intensive care management can have a sufficient, enduring impact.⁹ MRC programs across the country are acutely aware of this important social determinant of health and are continuously seeking to develop and streamline pathways into permanent housing for their consumers, necessitating innovative partnerships with Continuums of Care, affordable housing providers, and other community leaders.⁹⁴

CONCLUSION

In spite of numerous barriers, MRC programs have successfully developed innovative and replicable approaches to meet the behavioral health needs of their consumers. MRC programs' size, structure, and specific services vary greatly based on local needs and available resources, and the promising practices presented in this report are meant to provide reference-points that can be adapted and applied to various contexts. This resource represents the beginning of ongoing, dynamic work being done by MRC programs nationwide and demonstrates their commitment to continuously improving care for people experiencing homelessness.

APPENDIX A: PROJECT METHOD

Primary data source: In January 2022, NIMRC hosted three virtual listening sessions with representatives from geographically and structurally diverse MRC programs. Eleven people representing 10 MRC programs participated in these sessions. Listening session participants included MRC program administrators, behavioral health clinicians, medical providers, and case managers.

Informed consent was obtained from all participants, and each listening session was recorded. Recordings were carefully reviewed, and the notes were organized into themes and promising practices by NIMRC staff.

Supplemental data sources: Additional sources of data for this report included:

- A thorough review of relevant research.
- An August 2021 recording of an in-depth interview with a behavioral health clinician working in a MRC program.
- A recording of a panel discussion around behavioral health from the May 2021 Medical Respite Care Pre-Conference Institute of the National Health Care for the Homeless Council's Annual Conference and Policy Symposium.
- Discussions with the Respite Care Providers' Network Steering Committee in 2021.
- The written summary of a preliminary investigation into this topic conducted by a subject matter expert (SME) in late 2021.
- Notes from informal interviews with MRC programs in 2021 and 2022.

Revising and finalizing the report: Three SMEs, including two with lived experience of homelessness, reviewed the draft of this report. Revisions were made based on their feedback and recommendations. Additionally, listening session participants previewed the final report and confirmed the accuracy of their quotes and contributions.

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