

Street Homeless Solutions Joint Command Center: Overview and Best Practices Guide

This guide serves as a training tool, reference guide, and job aid for Joint Command Center (JCC) Crisis Coordinators and Community Assistants. The first section describes the history of the JCC, its structure, the roles and responsibilities of its staff, and some of its primary operations. In short, it is an overview of *what* the JCC does as a part of the NYC Department of Homeless Services (DHS, or Agency).

The second section focuses on best practices for staff working in the field. It provides guidance on *how* to help New York's most vulnerable. This section covers topics to help with work in the field, including harm reduction, motivational interviewing, and addressing client medical concerns. It also includes a section on self-care to help field staff see to their own needs to best meet the needs of the people we serve.

Finally, the guide ends with a glossary of terms with links to more information.

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Joint Command Center Overview

Formed within the NYC DHS Street Homeless Solutions (SHS) division, the JCC provides additional rapid-response capacity for street outreach and crisis intervention, and a focus on increased citywide coordination to support New Yorkers experiencing unsheltered homelessness both above ground and in the subway system (also referred to as “experiencing street homelessness” and/or “experiencing homelessness and living unsheltered;” and/or “experiencing homelessness and residing/living on the streets/subways”).

The JCC is a dedicated hub that enhances communication and coordination between the SHS division, relevant Agency partners, and outreach providers who might meet and engage people who are unsheltered under the HOME-STAT program, with the goal of continually strengthening citywide outreach efforts to help more New Yorkers who are unsheltered get the services—and ultimately, the housing—they need.

The JCC conducts interagency rapid outreach deployment from a central location in response to incoming notifications and requests-for-assistance across a range of channels, including 311, proactive canvassers, contracted outreach teams, partner Agencies, and more.

To address the most challenging cases of unsheltered homelessness involving clients with high needs—who often face the most significant, overlapping barriers, including mental health and substance use challenges—the JCC also helps coordinate the development of tailored interventions on a case-by-case basis to work toward a breakthrough to encourage these individuals to finally accept services and transition off the streets and out of the subways.

Contracted outreach providers and various Agency partners collaborate closely on deployment efforts and create individualized plans.

Joint Command Center Overview (continued)

Within the SHS division, the JCC coordinates with contracted outreach teams and canvassers under the HOME-STAT program to direct the efforts of existing street homeless response and prevention programs, with shared goals:

- Identifying people experiencing unsheltered homelessness.
- Building relationships through regular contact and concerted engagement with New Yorkers who are unsheltered focused on encouraging them to accept services and transition off the streets.
- Facilitating joint outreach operations with Agency partners to bring relevant expertise to the table and develop targeted interventions on a case-by-case basis.
- Coordinating responses to requests for outreach assistance from 311 calls.
- Connecting people who are unsheltered to dedicated social services and specialized resources, including low-barrier transitional housing programs such as Safe Havens and stabilization beds, which can be the first step toward permanent housing.

The JCC is a team of dedicated DHS staff, who help coordinate unsheltered outreach efforts, placements, and response. The role of staff members assigned to the JCC and HOME-STAT are clearly defined and distinct, but both units work very closely together at all times.

JCC Structure, Roles, and Responsibilities

The JCC is intended to be an adaptable team that responds rapidly to the changing needs of our city's most vulnerable New Yorkers. This section is an overview of some of the roles within the JCC and HOME-STAT and their core responsibilities.

In the Field: Community Associates and Crisis Coordinators

Community associates serve as “eyes on the street,” canvassing, noting, and reporting the location of individuals or groups of people who are vulnerable to the JCC, so that outreach teams, which may include licensed clinicians, can follow up and conduct further engagement. They may also directly engage with people on the street and offer help based on their judgment of the situation, while always prioritizing the safety of everyone present. Community associates are part of the HOME-STAT team and canvass Manhattan.

The primary role of community associates is canvassing. There are two types of canvassing: general and intensive. Where general canvassing focuses on observations, intensive canvassing focuses on interaction: providing people who are unsheltered with information about accessing social services and dedicated resources; learning more about their needs and relaying that information to the local community and service providers; and connecting receptive clients with social services and resources specific to their needs, including low-barrier transitional housing programs.

General canvassing involves staff members surveying the streets individually in an assigned area (called a ‘map’) and logging any observations and interactions they make during the day into the HOME-STAT app. Through general canvassing, the entire borough of Manhattan is canvassed at least once a month.

Intensive canvassing is generally organized in response to 311 service requests from the public, referrals from external stakeholders, or partner agencies requesting outreach assistance for people who are unsheltered in a specific area. Intensive canvassing is conducted in two-week increments with a focus on the area in question, which helps better understand trends in the area over time. This effort is similar to general canvassing in that it involves observation, interaction, and reporting.

JCC Structure, Roles, and Responsibilities (continued)

In the Field: Community Associates and Crisis Coordinators (continued)

Community associates operate the 311 inquiry line, responding to calls from City employees with concerns about people who might be living unsheltered. The community associates also distribute informational posters, flyers, and palm cards to libraries across the five boroughs, and may occasionally participate in information sessions at libraries to create awareness about the social services and dedicated resources available to people experiencing unsheltered homelessness.

Crisis coordinators are the backbone of the JCC. They engage and build relationships with people experiencing unsheltered homelessness with the goal of addressing the underlying issues that may have caused or contributed to their unsheltered homelessness in order to ultimately help these individuals transition off the streets. They educate and inform communities in areas where the needs of those experiencing unsheltered homelessness may be misunderstood, and provide information about DHS services, as well as community resources and nonprofit services such as food banks and health clinics.

To achieve these goals, crisis coordinators visit locations where people who are unsheltered frequently gather (which may be referred to as “hotspots”) to engage, offer social services, and work to gain their trust. Crisis coordinators cover all five boroughs and the subway system, with a greater focus on the areas surrounding hotspots. They can access CARES and StreetSmart³ from the field and help JCC managers coordinate during especially busy times. They are also responsible for supervising community associates.

Supportive Leadership: Managers, Program Administrators, and Assistant Commissioner

Managers at the JCC oversee day-to-day operations. They assign work to crisis coordinators and community associates and serve as their primary points of contact while doing outreach. Because of this, managers need to be prepared to handle many potentially urgent situations at any given time. Examples include responding to urgent requests from other Agencies, asking for outreach assistance, receiving status reports about 9.58 removals, and taking a lead role on high-needs cases and referrals from external stakeholders.

Managers read and generate reports about various JCC activities, participate in meetings on a variety of topics with other DHS staff, and are expected to review their supervisees' work and manage their time and leave. A manager must be prepared to shift focus as new priorities emerge and may delegate some portion of these tasks to a crisis coordinator on any given day.

Supportive Leadership: Managers, Program Administrators, and Assistant Commissioner (continued)

Program administrators, as the most senior staff on shift at any given time, provide support and guidance to other JCC staff, including managers. As a result, they have daily tasks similar to those of the manager including creating and monitoring reports, participating in meetings, etcetera. The difference is in their general area of focus – they have an eye on the overall functioning of the team and the division. Program administrators also typically have more clinical experience and can provide both administrative and clinical oversight to JCC operations.

Program administrators act as liaisons to other program divisions within DHS (especially for strategic planning purposes), service providers, and Agency partners. At the same time, they are expected to have an in-depth understanding of the work of staff in the field, as they may be called upon to support that work directly. One example of this is overseeing DHS' response to extreme weather (also known as Code Red/Code Blue events).

The **assistant commissioners** act as liaisons with senior leadership at DHS and the Department of Social Services (DSS) and with other partner Agencies, such as the Mayor's Office of Operations. They manage meetings with elected officials and community boards, ensure the completion of projects and follow up with the community, and oversee the completion of requests coming through 311 and other channels.

JCC Operations

The JCC focuses its attention on some New Yorkers who are particularly vulnerable: those living on the street and in the subway. Below is a brief description of the essential functions of JCC operations.

Canvassing

As mentioned above, crisis coordinators and community associates regularly canvass throughout the city to complete daily assignments from JCC managers. The JCC collaborates with contracted nonprofit outreach provider partners to coordinate support and further outreach in the field.

Provider partners and their areas of operation:

- Bowery Residents' Committee – NYC subway system
- Breaking Ground – Brooklyn, Queens, and Manhattan
- BronxWorks – Bronx
- Manhattan Outreach Consortium (MOC) – Manhattan (MOC is composed of the Center for Urban Community Services (CUCS), Goddard Riverside, and Breaking Ground)
- Project Hospitality – Staten Island

311 Service Requests

The JCC and HOME-STAT teams respond to 311 service requests made by City employees and the public reporting the presence of people who are unsheltered. Crisis coordinators then go out to investigate the situation, assess how to best provide services where appropriate, and respond to the report.

“Friends and Family” is a special designation attached to 311 service requests from a friend or family member who believes their loved one is experiencing unsheltered homelessness. This request includes a description of the person and their last known location. While the request remains open, the JCC sends staff regularly to the location to try to locate the person.

JCC Operations (continued)

Interagency Referrals

Interagency referrals are approached similarly to 311 service requests in that they are reported by partner agencies, and field staff go out to assess the situation. Interagency referrals may come from partner City Agencies, and/or from the DSS Inter-Governmental and Legislative Affairs (OIGLA) office.

Assessments

Assessments are made in direct communication with contracted outreach teams and the JCC manager-on-duty. The goal is to determine the best placement for each client in the SHS system. Most often this means a bed at a safe haven or stabilization site, but it may include a referral to another DHS division if the client is willing to enter a more structured shelter environment. Factors considered include chronicity (length of time living on the street) and mental health and physical health needs.

Referrals to Safe Havens and Stabilization Beds

When an assessment concludes that the appropriate placement for a client is a safe haven or stabilization bed facility, the JCC reviews the list of available beds and works with each client to find a bed they will accept. For example, many clients prefer to stay in the borough they know best.

Stabilization beds are low-barrier beds intended for clients who are able to live independently and who do not have high medical or mental health care needs. Clients must be on the caseload of an outreach team to be considered eligible.

Safe Havens provide an immediate alternative transitional housing resource with flexible program requirements and robust case management services, which outreach teams have found are more effective than traditional shelter for helping unsheltered homeless individuals stabilize their lives.

9.58 Removals

In accordance with Mental Hygiene Law §9.58, A physician or qualified mental health professional who is a member of an approved mobile crisis outreach team is authorized to remove, or direct the removal of, a person to a §9.39 hospital or C.P.E.P. for the purpose of evaluation for admission, "if such person appears to be mentally ill and is conducting himself or herself in a manner which is likely to result in serious harm to the person or others." "Qualified mental health professional" means a licensed psychologist, certified social worker or registered professional nurse approved by OMH to serve in a mobile crisis outreach program.

JCC Operations (continued)

9.58 Removals (continued)

In other words, if outreach staff meet someone who is unsheltered and may be a danger to themselves or others, they may call the JCC to request clinician assistance. The clinician completes an observational psychiatric evaluation and, based on their assessment, may call for the person who is unsheltered to be brought to a hospital with appropriate psychiatric services, where they may be admitted for further care.

Addressing Street Conditions

The JCC coordinates with City Agency partners (example: Department of Sanitation) and property owners to address reported street conditions. When the City addresses physical conditions on the street, the Department of Sanitation is present and the JCC coordinates to provide support and outreach services. In these efforts, depending on the location of the condition, the Department of Transportation or the Parks Department may participate.

Before and during the operation, outreach teams encourage individuals present at the site to accept services, including shelter placement. JCC works in collaboration with contracted outreach teams and typically interacts with people present at the site at least three times in most cases to do the following:

1. Investigate the initial report and offer services as appropriate
2. Deliver a letter of notice in advance of the physical condition being addressed
3. On the day the condition is addressed, continue to engage, provide assistance, and offer services

When a physical condition is addressed, JCC crisis coordinators are present onsite to engage people who are unsheltered and offer social services and assistance while encouraging them to accept a transitional housing placement. Contracted outreach staff as well as JCC staff provide this assistance. During the effort, it is critical that individuals' vital records or important documents (such as identification, medical records, etc.) are NOT discarded.

JCC Operations (continued)

Addressing Street Conditions (continued)

Here are the definitions that our dedicated HOME-STAT outreach teams use when assessing conditions that need to be addressed:

- A “pop-up” location is defined as a condition that appears quickly and is usually temporary and can be addressed quickly, hence ‘pop up’, often including some level of debris such as carts or cardboard boxes
- A “street condition” is an outdoor location with a fixed, visible structure, which may be in remote areas, and is typically a place where two or more people have congregated.

Hotspots

The JCC engages clients at known locations around the city where people experiencing unsheltered homelessness tend to gather. Hotspot locations change frequently and are often seasonal. DHS and contracted outreach providers regularly visit these areas to engage individuals, offer services, and try to convince anyone present to accept services, including placement at a transitional housing facility.

Multidisciplinary Team Meetings

Multidisciplinary Team Meetings (MTMs) are used to review and plan next steps for clients on the Top 50 List of the clients who are unsheltered and have the most significant challenges and service needs. DHS compiles the Top 50 List together with other organizations and partner agencies to reach those who are most vulnerable and hard-to-reach with services and individualized supports. Those on the list receive the highest priority for services and shelter, with solutions custom-tailored to each person’s unique needs and circumstances. These meetings involve DHS staff at the manager-level or higher as well as a variety of partner agency staff; the decisions made during these meetings often inform field assignments and other JCC actions.

Joint Command Center Best Practices

The core work of the JCC involves engaging people experiencing unsheltered homelessness. The sections below provide best practice guidance for various aspects of engagement. Not all sections will apply to every interaction. All people – both City employees and members of the public – are unique; no blueprint or plan works for every situation.

These best practices are just that – practice. The term “practice” refers to deliberate actions taken to work in a way that, above all, honors and empowers the people we serve.

In all our work, we must strive to always act with compassion and respect. The best practices described here are intended to support staff in achieving this goal and in striving to meet the needs of those who are New York’s most vulnerable.

Trauma-Informed Approach

Respect and compassion for the individuals we serve begins with an understanding that the experience of homelessness is traumatizing in both an acute and ongoing sense. The experience of losing a stable place to live, no matter how many times it has occurred, is a fresh trauma, and continuing to live without stability is an ongoing trauma that does not end with temporary placement in a DHS facility.

The experience of trauma is still poorly understood, as are its effects on physical and mental health. Trauma has been linked to a wide variety of physical and mental health challenges and difficulties with executive function. Individual traumas are unique, and each person handles their experiences differently.

In practice, this means you should always be mindful of how your appearance and demeanor may affect others, and pay attention to how people are reacting to you. Respecting others’ boundaries is vital to building trust. At the same time, understand that past experiences make it hard for many people to communicate their boundaries. When in doubt, err on the side of caution.

Here are a few specific tips:

- Speak calmly and at a conversational volume – do not yell or raise your voice.
- Give people their personal space – let them choose how close to stand to you.
- When interacting with someone who is seated, avoid looming over them – ask if you may sit down next to them to talk.
- Be mindful of the associations people may make based on your accessories or clothing; a government ID on a lanyard, branded clothing, etc.

Joint Command Center Best Practices (continued)

Person-centered Approach

A person-centered perspective prioritizes the dignity and independence of the client in any client-staff relationship. Being person-centered means focusing on the client and their expressed needs and wants.

JCC staff are expected to treat each client with respect. This means treating each person as an individual, and enabling them to achieve their own objectives, in their own time. We must each strive to be mindful of the institutional power we hold and access through our positions in government, and to be cautious about how and when we choose to use that power.

Imagine a setting where a crisis coordinator notices a man sitting on a street corner at the base of a pedestrian crossing sign. The crisis coordinator stops to speak with him for a few minutes, and notices the man has an open cut on one of his bare feet. It is not bleeding, but it appears deep. While the coordinator could call a nurse immediately, showing sincere concern and asking the man if he would like medical care puts that decision – and power – in his hands.

Client Engagement

Gaining the trust of our known and prospective clients and building a rapport and relationship with them is vital to the work we do from the first meeting to permanent housing, and all stops in between. Developing a relationship starts with getting to know each person, which may include approaching them multiple times and in different ways – some people simply do not “click,” but another day or with another staff member, a prospective client on the street may start to open up a little.

As in all other relationships, first impressions are important. Many people experiencing unsheltered homelessness have already been approached by DHS or outreach staff before, and those experiences may have been traumatic. While you cannot change these early impressions, you can do your best to start fresh. Always demonstrate respect and compassion.

Respect the individual’s personal space, their belongings, their feelings, their beliefs, and their reactions. Introduce yourself by name and explain why you are there and what you hope to talk about. Act at all times with compassion: ask if they have eaten, if they have gloves or a mask to protect against the spread of COVID-19, and listen attentively to what they say even if it seems unrelated to your questions. Stay attentive and responsive to non-verbal signals, which may indicate they are becoming frustrated or simply not connecting. Balancing persistence with empathy is key.

Joint Command Center Best Practices (continued)

Cultural Sensitivity

Being culturally sensitive means being aware, knowledgeable, and accepting of a culture that is not your own. It also, increasingly, means accepting sub- and counter-cultures that may exist within a given culture. While the term “culture” is often used to refer to ethnicity or national origin, culture is an expression of shared experience, which goes beyond family ties.

All sorts of shared experiences produce an affiliated culture, and that culture is expressed through often-unspoken norms of behavior. For example: in the NYC subway it is frowned on to sit directly next to someone if a seat farther spaced is available. This is an unspoken norm that everyone who rides the subway learns, usually without being told.

There is a culture unique to life on the streets of New York City. Likewise, there is a culture unique to the DHS workplace, a culture within the SHS division, and another culture unique to the JCC. When you interact with someone who is unsheltered on the street, your respective cultures are also coming into contact. A person-centered approach to providing social services requires us to respect and validate all people’s experiences.

Culture is built on shared experiences, but not everyone is treated equally or made to feel equally welcome everywhere. This is vital to understand, as people experiencing homelessness are often subject to discrimination. Most people who are homeless are also subject to further discrimination due to race, gender, religion, or some other aspect of their identity. Often, this discrimination comes from people who have some form of power over the individual. It may even have come in the past from institutions that were supposed to help them, including this one. As a result, many people become suspicious of or even hostile toward authority figures and government Agencies, including DHS.

As outreach staff, you have the opportunity and responsibility to connect with clients in a more compassionate way than they have experienced in the past, in order to begin rebuilding trust. Do your best to understand and accept the cultural and personal history of those we serve, even (and especially) when they may not respond with equal courtesy. That is the best way to really show them you are here to listen, to understand, to respect, and to help.

Joint Command Center Best Practices (continued)

Ethics

As a concept, ethics define a system of moral principles. DHS' mission states that we do our work with accountability, empathy, and equity. We must also add harm reduction to this list, especially in the SHS division, where individuals face some of the most significant challenges and service needs. All government agencies have great power to intervene in the lives of the people; as a life-line Agency upon whom people depend when times are hardest, we have a responsibility to wield that power carefully and responsibly, and as much as possible to give that power to those who are most vulnerable.

Ethics are most often discussed in academic contexts, but as relates to human services, ethics need to be put into practice and the resulting actions examined continually. The opportunities for doing so cannot be formally laid out as a matter of policy – it is the duty of each of us to consistently examine our role and actions and to strive to the highest ethical standards in our field of work, both in our interactions with people experiencing unsheltered homelessness and with colleagues.

Effective Communication

Effective communication is not simply a set of instructions; it is a skill that must be intentionally practiced and improved. As with other skills outlined in this guide, your communication skills will develop along with field experience. It is never too late to improve your skillset. Relevant training opportunities may be available, but communication skills can also be developed on your own. Choosing one aspect of (for example, initial approach) to focus on, and asking for feedback from colleagues are two possible ways of improving.

There is no one correct way to communicate. Simply put: communication is effective when it works. This requires a clear sense of the goal of a given interaction. In outreach, the objective of most interactions is one of the following:

- To build rapport, relationships, and trust
- To inform (most often regarding social services or transitional housing resources)
- To convince (usually convincing an unsheltered individual to accept services or a transitional housing placement – a first step on the path back to stability)

Joint Command Center Best Practices (continued)

Effective Communication (continued)

Various factors may either reduce or improve the chances that a chosen communication strategy will work. Many of these factors will be outside your control, such as: a client's mood, their past experiences, and their biases. But there are some factors within your control. Below are some examples of best practices for effective communication:

- When working in a team, choose one person to lead the interaction, and be prepared to switch if they are more willing to speak to the “backup” partner
- Pay attention to your physical approach; avoid cornering or crowding people
- Introduce yourself first using your name and pronouns; ask “what should I call you?” or “what name should I call you by?”
- Start a general conversation: don't just ask if someone needs services or if they want to come inside; try to build a caring, professional relationship
- Ask clients if they would be more comfortable talking in another language; call the JCC to access the language line or ask a manager if they can find someone who speaks your client's primary language

Motivational Interviewing

Motivational interviewing (MI) is a practice used to help clients find internal motivation to make changes to their lives and maintain those changes. MI is typically used in a clinical setting, but the core principles and methods can be used by anyone to improve their engagement efforts. The goal is to guide the conversation, over time, in a way that allows the client to make their own decisions and take action.

The basic principles of MI are:

- Find motivation: identify the client's goals and hopes
- Clarify the conversation: listen for and clarify the difference between the current and desired situation
- Validate experiences: demonstrate empathy for the client's perspective and situation
- Accept resistance: avoid arguing or preaching
- Support self-determination: provide support for change; avoid making decisions on behalf of others

Joint Command Center Best Practices (continued)

Motivational Interviewing (continued)

The SHS division makes unique use of motivational interviewing in the sense that at least one initial goal is assumed: there is an assumption that a given client does want to live indoors. The focus is on finding ways to move past their resistance, and discovering the source of that resistance, in order to provide each person with service options they want and will continue using in the long term.

Motivational interviewing is a skill that must be built and practiced deliberately. Seeking out opportunities for structured training offered by DHS in this area, especially when first starting out, may be especially helpful toward building the right skillset. Getting feedback from coworkers can also be very helpful – a debrief immediately after leaving an interaction, while the situation is still fresh, can be one of the best ways to improve.

Harm Reduction Principles

Harm reduction is a theory and practice that acknowledges the harm caused by situations like living unsheltered, substance abuse, or mental illness. In a harm reduction model, the goal is to recognize that not all harmful behaviors can be stopped, nor all harmful situations avoided. Instead, harmful situations and actions are identified, and a plan is made to reduce the *degree* of harm.

For example, an addiction treatment center may operate a needle-exchange program, thus allowing users of intravenous drugs like heroin to obtain clean needles to inject with. This reduces the harm done by reducing the likelihood of spreading bloodborne pathogens by re-using or sharing needles.

Because you may see a variety of harmful behaviors in the course of your work, you should strive to engage clients using an approach which is informed by harm reduction principles. Consider: What harm is being done, and is there potential to reduce that harm even by small degrees? If they are not interested in going to a mental health clinic, would they be willing to talk to a mobile crisis team? Often the first and hardest step is acknowledging that a change may be needed or even helpful – motivational interviewing techniques (above) can be useful in this regard.

Never engage with someone actively using substances or drinking alcohol. If you witness someone drinking or using substances, assess the situation from a distance. If they appear to be a safety risk to themselves or others, call the JCC for further instruction. In general, any time there are safety concerns, call the JCC. If harm is actively occurring or you find yourself concerned for someone's imminent safety, call 911, request Emergency Medical Services, and remain at the location to await their arrival.

Joint Command Center Best Practices (continued)

Community Services and Resources

The more time you spend in the field, the more you will learn about the needs of people experiencing unsheltered homelessness, and what community services are available in various boroughs and neighborhoods around the city. However, every person and situation is unique. No matter your degree of experience, you will find yourself in situations where you are unsure what to do or unsure what help might be available.

Do not hesitate to ask for help or guidance when you need it. The JCC operates 24/7 and there is always a manager on duty whose role is to support field staff in assisting New York City's most vulnerable people. If you feel unsure, always call the manager on duty.

In some circumstances, the manager on duty may escalate a question or concern to the program administrator, especially in cases that would benefit from more clinical knowledge. They may also contact a contracted outreach provider team for additional support, especially if a client has an existing connection to that team.

Finally, always keep in mind the resources you can access and in turn provide to clients:

- JCC crisis coordinators can access CARES and StreetSmart on their work-assigned cell phone, which may have further information on a given client's history and needs.
- Street Sheets are resource lists with the location and contact information of resources like food pantries, drop-in centers, hospitals, etc. Always keep several of these with you and give them freely to known and prospective clients.
- Palm cards are business-card-sized documents listing contact information for outreach teams, shelter intake information, the location of specialized resources like Drop-In Centers, and NYC's 311 Infoline

When providing this information to clients, try to confirm that a given client has the skills and resources to use them. Are they able to travel to the location? Do they have access to a phone they can use to call the numbers on a palm card? Are they able to see and read the Street Sheet? Handing out these resources will only help if the people receiving them can understand and use them.

Joint Command Center Best Practices (continued)

Documentation and Records

It often takes many interactions before an unsheltered individual decides to accept a transitional housing placement. As experienced outreach teams will tell you, it may take hundreds of engagements to build trust and encourage someone to make the life-changing transition off the streets. It is important to document each of those interactions as completely as possible, as these records help find the right set of individualized services for each client and may later provide information to another service provider vital to helping a given client on their way to permanency. There are two key times when records should be created:

Interactions

All interactions should be documented in StreetSmart. These records should include:

- What was the location (cross-streets or address)?
- What were the names of any known clients present?
- What issues and/or needs were observed?
- What services were offered? Were they accepted?
- What is the recommended follow-up (if any)?
- Any additional information you may have learned about someone's personal history, circumstances, or experience of homelessness.

Transition and Debrief

When transitioning from one shift to another, create a summary of your shift for managers to review. This should include:

- How many clients did you engage with over the course of the shift?
- How many clients did you screen for medical needs?
- How many hotspots did you visit and what happened at each?
- How many individuals were you able to connect or refer to services of some kind, including shelter?

Medical Concerns

People living on the street often go without medical care. Inability to pay and/or lack of insurance, past trauma, and lack of trust are all common reasons. When interacting with clients on the street, look for signs that they may need or benefit from medical care. Do not be afraid to ask questions. If they have a cough, ask how long they have had it and whether it is being treated. In the case of a wound such as a cut or sore, ask if it hurts, how it happened, and how long ago. In either case, always ask if they are getting medical care, and offer to get them some help.

The DHS Office of the Medical Director (OMD) publishes guidance for certain situations, such as when to call 911, and what to look for in the event of a Code Blue or Code Red (very cold or hot weather, to a degree that could cause harm). When in doubt, always contact your supervisor, and stay in regular contact with the street medicine teams. The following is a summary of OMD's guidance.

Urgent Medical Attention

In the following situations, call 911 and the JCC to access a street medicine team:

- Unresponsive (cannot be aroused – not just sleeping – if trained, administer naloxone)
- Shortness of breath
- Chest pain
- Acute abdominal pain
- Coffee ground-colored vomit
- Vomiting or coughing up red blood
- Changes in vision
- Loss of sensation
- Sudden weakness on one side
- Extreme headache
- Delirium (acutely disturbed state characterized by restlessness, illusions, and incoherence of thought and speech)
- Severe alcohol intoxication
- Slurred speech
- Difficulty maintaining balance
- Slowed reactions
- Aggressiveness
- Imminent danger to self – reports suicidal ideation with intent or plan

Medical Concerns (continued)

Urgent Medical Attention (continued)

- Harm to others – reports intent to harm others
- Acute depression (withdrawn, refusing to engage when the client usually engages with an outreach team, poor appetite)
- Presence of delusions, violence, panic attacks, and significant, rapid changes in behavior
- Floridly psychotic- not oriented in person, place, time; talking to self in an agitated manner, brandishing fists

Non-Urgent Medical Attention

In the following situations, contact a supervisor to discuss medical follow-up:

- Swollen legs
- Black toes or fingers
- Wounds that are inflamed, seeping, or covered in yellow crust
- Tremors
- Yellow “whites” of eyes (that are not normal for them; ask if this is a recent change)
- Yellow skin/ palms of hands

Other Symptoms of Concern

If you notice other symptoms that cause concern, ask the following questions and contact a supervisor if the answer to any of the below is “yes”:

- Have you been discharged from a hospital in the last 30 days?
- Do you need to see a doctor?
- Do you have any chronic medical conditions?
 - Follow up: Are you seeing a doctor for your medical condition?
- Have you had surgery in the last 30 days?

Medical Concerns (continued)

Code Red

Outreach teams should keep the Code Red Priority List in their vans and at the office to ensure clients are visited per the operational standards referenced in Code Red.

Identifying Heat-Vulnerable Clients

Consider the following factors when identifying heat-vulnerable clients:

- Chronic health conditions, including:
 - Cardiovascular, Coronary Artery Disease, Atrial Fibrillation
 - Renal (Kidney) disease
 - A respiratory disease, such as Chronic Obstructive Pulmonary Disease (COPD)
 - Obesity (BMI > 30)
 - Diabetes
 - High Cholesterol
- Serious mental illness, such as schizophrenia or bipolar disorder
- Cognitive or developmental disorder that impairs judgment or self-care, such as dementia
- Cancer
- Stroke
- Difficulty thermoregulating or use of medications that can cause dehydration, including:
 - Diuretics, or “water pills”
 - Anticholinergics, such as Cogentin
 - Neuroleptics or anti-psychotic medication, such as Risperdal, Seroquel, and Abilify
 - Drug or alcohol misuse
 - Social isolation
 - Limited physical mobility

Medical Concerns (continued)

Code Red (continued)

Guidance for Heat-Vulnerable Clients

Take the following steps once heat-vulnerable clients are identified:

- Advise clients to increase fluid intake during hot weather. Recommend self-monitoring of hydration for people who have health conditions sensitive to fluid balance or who use medications that can cause dehydration.
- Engage staff to frequently call or otherwise remotely check on heat-vulnerable clients to help them stay cool and well-hydrated before and during hot weather.
- Discuss with clients and staff the signs and symptoms of heat-related illness or worsening of chronic medical conditions and provide guidance about when to call 911 or go to an emergency room.
- Watch for signs and symptoms of heat-related illness, including heavy sweating, nausea or vomiting, weakness, dizziness, headache, loss of appetite, decreased energy, or loss of consciousness, and call 911 when necessary.

Code Blue

Outreach teams should keep the Code Blue Priority List in their vans and at the office to ensure clients are visited per the operational standards referenced in Code Blue.

Call a supervisor for at-risk individuals identified through the checklists below who refuse to come indoors and who do not meet the NYS Mental Hygiene Law, section 9.58, or EMS threshold for involuntary transport.

Medical Concerns (continued)

Code Blue (continued)

Assessing Clients During Code Blue

At all times, but especially when the weather is dangerous (extreme cold, heat, etc.), all individuals experiencing unsheltered homelessness should be assessed using the following Vulnerability Index:

- More than three (3) hospitalizations or emergency room visits in the last year
- More than three (3) emergency room visits in the previous three (3) months
- Aged 60 or older
- Cirrhosis of the liver
- End-stage renal disease (history of dialysis)
- History of frostbite, immersion foot, or hypothermia
- HIV/AIDS
- Tri-morbidity: co-occurring psychiatric illness, substance use disorder, and chronic medical condition

Determining the Presence of Risk Factors

- Exposure to the elements:
 - Living conditions (structure or lack thereof)
 - Appropriate dress (layering, and head, hands, and feet covered)
- Open fires, “contained fires,” and the risk for carbon monoxide poisoning
- Inability to be logical and goal-directed toward meeting basic needs
- Active signs of hallucinations or gross disorganization
- Alcohol dependence (current)
- Known history of heart disease, diabetes, peripheral vascular disease and/or severe psychiatric illness

Medical Concerns (continued)

Code Blue (continued)

Detecting Frostbite

This guide should be used to determine if there is a need for medical attention due to potential frostbite. During a Code Blue, outreach teams should visit people at-risk on the streets frequently.

To assess for frostbite, here are three questions that must be asked when the temperature is below 32 degrees Fahrenheit (F):

1. Have you experienced a pins-and-needles sensation in your fingers, toes, nose, or ears?
2. Has your skin on your fingers, toes, nose, or ears turned a shade of white?
3. Is the skin on your fingers, toes, nose, or ears softer than usual?

If the person answered YES to any **one** of the questions above, then he/she may be experiencing frostnip. Proceed to the next series of questions:

1. Have you recently (in the past day) had or do you currently have any blisters on your fingers, toes, nose, or ears?
2. Do your fingers, toes, nose, or ears feel numb, waxy, or frozen?

If the person answered **yes** to **either** of these two questions, assist the client indoors (shelter, emergency room, etc.) as he/she is experiencing superficial frostbite and is at high risk for deep frostbite. If the client refuses to go with the team, the team should call 911 and describe the symptoms of incipient frostbite to the dispatcher.

Medical Concerns (continued)

Code Blue (continued)

Hypothermia Signs and Symptoms

Hypothermia is marked by unusually low body temperature (below 96 F), which is well below the body's normal temperature of 98.6 F. Severe hypothermia can cause an irregular heartbeat leading to heart failure and death. Hypothermia usually comes on gradually; often people are not aware that they need medical attention. Symptoms take effect in three stages:

Stage 1: Mild hypothermia: bouts of shivering; grogginess; muddled thinking

Stage 2: Moderate hypothermia: violent shivering or shivering which suddenly stops; inability to think and pay attention; slow and shallow breathing; slow or weak pulse

Stage 3: Severe hypothermia: shivering stops; loss of consciousness; little or no breathing; weak, irregular or non-existent pulse

What **NOT TO DO** if hypothermia is suspected:

- Do not apply heat to arms and legs or give the person a hot bath. This could force cold blood back toward the heart, lungs and brain causing the core body temperature to drop. This can cause death.
- Do not massage or rub the person. People with hypothermia should be handled gently because they are at risk of cardiac arrest.
- Do not give alcoholic beverages. Alcohol lowers the body temperature.

Medical Concerns (continued)

Code Blue (continued)

Hypothermia Signs and Symptoms (continued)

What **TO DO** if hypothermia is suspected:

- CALL 911 for any degree of suspected hypothermia; describe the person's condition to the dispatcher.
- If the affected person is alert and able to swallow, have the person drink a warm, nonalcoholic beverage to help warm the body.
- Move the person out of the cold. Preventing additional heat loss is crucial. If unable to move the person out of the cold, shield the person from the cold as best as you can.
- Remove wet clothing and replace it with a dry covering. Cover the person's head. Try not to move the person too much. Cut away clothing if necessary.
- Insulate the person's body from the cold ground. Lay the person face-up on a blanket or warm surface.
- Monitor breathing. A person with severe hypothermia may appear unconscious with no apparent signs of pulse or breathing. If the person's breathing has stopped or appears dangerously low or shallow, administer naloxone if you are a certified Opioid Overdose Responder. If the person is unresponsive, begin CPR, and administer naloxone, if trained.

Sustainable Practices

“You cannot pour from an empty cup.”

This saying imparts a simple wisdom: that in order to take care of others, we must first see to our own basic needs. To do otherwise is to risk causing unintended harm, whether through an inability to show compassionate respect, a failure to listen, or unconscious bias and resulting discrimination. We are all human and deserving of equal respect and compassion – and that begins with caring for yourself.

Staff who work in social services also benefit from developing a heightened self-awareness. Coming to terms with our own experiences and perspectives can help us move past them to focus on others in need.

Strengths-Based Approach

Taking a strength-based approach means emphasizing collaboration rather than power structures, treating everyone as an equal partner and an expert on their own situation, and treating everyone with dignity and respect. In order to fully respect others, we must first honor our own needs and experiences, and acknowledge our own worth.

Resilience

Resilience is the ability to be affected by adversity, failure, and even trauma without being overwhelmed or succumbing to hopelessness, apathy, or cynicism. This term has much in common with self-care, and practicing self-care is one way to support resiliency. However, resiliency is a deeper quality.

Many people believe resilience is determined by genetics or upbringing. While there is evidence that those circumstances do influence our baseline level of resilience, it is both a personality trait and a skill, and one which can be built with intention and practice.

How do we practice and build resilience? Here are a few (but not the only) ways:

- ✓ Embrace change, while acknowledging that it may not be easy. Change is inevitable – we can only choose whether to resist and fail to avoid change, or to embrace it and learn to seek out the positive aspects. Embracing change is a choice you can make.
- ✓ Know yourself. There are many ways to approach this and no reason to choose just one. Mindfulness practice, journaling, and therapy are three often-recommended ways to improve our self-understanding, and there are many types of each to choose from.

Sustainable Practices (continued)

Resilience (continued)

- ✓ Learn to identify and acknowledge your strengths and the times you have already been resilient in the face of difficulties.
- ✓ Take care of yourself. Maintain your physical and mental health, your relationships, and your interests. Treat yourself with compassion and respect, and respond to your own needs. This is harder than it sounds, especially for human services professionals whose role is to attend to the needs of others. Speak to your supervisor about any experiences you have in the field that have unsettled or disturbed you.

Intervention and Coping

Intervention relates to unexpected stressors or moments when our regular mechanisms for resiliency are tested. Maybe a client you have a connection with has been hospitalized, or someone in your own family is ill. Or it may simply be a day when several small stressors came in at once: lost sleep, transit delays, approaching deadlines, etc. Regardless of reason, it is helpful to plan for those days when stress builds up. Having a plan means you don't need to find a solution during a time when you are already experiencing high stress – you can simply follow your plan.

There are many coping mechanisms to choose from, and everyone has different responses. Find and test strategies that work for you and make a plan that you can turn to when you need it.

Some examples of coping interventions:

- Take a short walk outside
- Engage in a contemplative or mindfulness practice (for example, meditation or, depending on your spiritual tradition, prayer)
- Breathe slowly through your nose for 15 seconds
- Write affirmations (this works best for those with high self-esteem)
- Write about something you enjoy doing (this works best for those with low self-esteem)

Sustainable Practices (continued)

Person-Centered Practice

At DHS, we take a client-centered approach to work. In managing ourselves when at work, we must also take a person-centered approach. Our outlook affects the way we frame our experiences, and those experiences affect the way we approach others. As human services workers, we each have the potential to do great good, but also great harm. In order to approach our work in a way that does the most good, we must understand where each of us comes from. Understanding ourselves is vital to doing this work.

Mindfulness practices, contemplative practices, and therapy can all be used as vehicles for understanding ourselves. Any ongoing effort in this area is a step in the right direction.

Cultural Sensitivity and Anti-Oppression

We bring our past experiences and cultural history with us into all our interactions, whether with clients or coworkers. Homelessness is a social problem that is the result of, among other things, systems of oppression. We each have a responsibility to understand the ways we may contribute to that oppression, both through our role as agents of the government and through our own personal privilege.

If we avoid coming to terms with our own past experiences, they will come through in subconscious ways in our interactions with others. This difficult process of inner reflection is vital to the outer work of putting our own comfort aside in order to focus entirely on the needs of others.

This nuanced work looks different for each person. Here are a couple possible starting exercises:

- Write down the ways you hold privilege. Consider areas such as your race, education, physical and mental health, and work. In what ways might this privilege blind you to the ways that others might experience oppression?
- Notice the ways in which you judge others. Making judgments is an essential part of human interaction – we need to make judgments in order to understand tone, for example – but not all judgments are equally helpful. In what ways might these judgments unintentionally lead to harm?

Sustainable Practices (continued)

Cultural Sensitivity and Anti-Oppression (continued)

Try to remain mindful and pay close attention to any preconceived notions you have, especially about clients. People often pick up on what we expect from them, and generally do what they are expected to do. If you expect a client to become agitated, you may end up behaving in a way that contributes to that very reaction. Try to approach each interaction with a clean slate.

Trauma-Informed Approach

Trauma-informed care is vital not only to understanding the needs of people experiencing homelessness – it is also vital to creating and maintaining a supportive and effective working environment. Working daily with a traumatized population passes a sort of “trauma contagion” on to workers. The solution? Improving our collective immune systems on an individual and organizational level.

A trauma-informed mindset is similar to a person-centered mindset. Trauma is subjective, and thus traumatic experience must be understood in the context of the individual. This personal work can be divided into three areas (which do not need to be approached in any particular order):

- Understanding your own triggers and reactions to those triggers
- Using coping mechanisms, and
- Practicing ongoing self-care

Compassion Fatigue

Sometimes called Secondary Traumatic Stress (STS), compassion fatigue is a risk to all those in caring professions, particularly those who work with individuals who have experienced trauma – as all people experiencing homelessness have. Understanding and prevention is vital, as compassion fatigue can result in reduced concentration, feelings of helplessness or numbness, irritability, lack of satisfaction and lowered self-esteem, social withdrawal, physical aches and pains, a reduced ability to feel empathy, and ultimately burnout.

Sustainable Practices (continued)

***Trauma-Informed Approach* (continued)**

Compassion Fatigue (continued)

Compassion fatigue is not well understood, but is gaining recognition among healthcare practitioners, social services providers, disaster response personnel, and numerous other fields. As the response to homelessness spans all the above-mentioned areas and more, it is especially important to practice prevention.

Resilience is key to preventing compassion fatigue. Learning and practicing stress-management techniques such as regular exercise and mindfulness practice help, as does building and maintaining strong social supports. Establishing professional boundaries and understanding that not every outcome will be positive, nor is it within your control to make it so, can also help.

Self-Care

Self-care is any activity we do to care for our physical, mental, and emotional health. What counts as “self-care” is often subjective, as something that is restorative to one person may be irritating or tiresome to another. For this reason, self-care is *not* anything we do “for our own good” – it must feel restorative. Sometimes our self-care needs change. For example, baking may be a self-care activity during an average week, but during an especially stressful one the cleanup may add one too many tasks to the to-do list.

To get you started, here are a few potential self-care goals. Pick one of these and think of an action you enjoy that can help you reach that goal:

- Set boundaries where possible so as to not over extend in an unsustainable way
- Get enough sleep
- Eat a healthy diet
- Stay physically fit
- Take time to relax and unwind
- Strengthen relationships with friends, family, and loved ones
- Create something
- Laugh more

The NYC Office of Labor Relations also offers a series of programs collectively referred to as WorkWell NYC, which encourage all City employees to actively plan for and engage in comprehensive self-care.

Glossary of Terms

9.58 Removal

A law and procedure by which a qualified clinician can judge someone a danger to themselves or others and call for them to be brought involuntarily from the street into a mental health facility for further assessment and treatment.

Anti-Oppression

A framework that challenges the dominant societal beliefs through the empowerment of those who are oppressed. Attempts to eliminate systems of oppression such as those based on race, gender, orientation, abilities, and age to confront and eradicate the class system in which we currently live.

Chronicity

A term used for service eligibility purposes. A person who “has chronicity” has experienced street homelessness for at least nine months out of the last two years (24 months).

Code Blue

A policy for times of extreme cold during which additional measures are taken to protect people experiencing homelessness from the cold, including more active outreach and changes to regular intake procedures.

[\[DHS Code Blue policy\]](#)

Code Red

A policy for times of extreme heat during which additional measures are taken to protect people experiencing homelessness from the heat, including more active outreach and changes to regular intake procedures.

[\[DHS Code Red policy\]](#)

Cultural Sensitivity

The knowledge, skills, attitudes and beliefs that enable people to work well with, respond effectively to, and be supportive of people in cross-cultural settings.

Drop-In Centers

Specialized facilities that allow people experiencing homelessness to come indoors, rest, bathe, and access services. Each provides basic necessities such as meals, clothing, showers, limited storage, and referrals to other social services. Located in all five boroughs and open 24/7.

Effective Communication

The ability to convey information to another effectively and efficiently.

Glossary of Terms (continued)

Encampment

Areas where fixed or temporary structures have been built as shelter or dwellings, which violate city administrative codes.

Ethics

A system of moral principles. Concerned with what is good for individuals and society; also called moral philosophy.

General Canvassing

An operation in which community associates, responsible for canvassing Manhattan from Canal to 145TH Street, travel through assigned zones to observe and report the presence and status of people experiencing homelessness.

Harm Reduction

An approach that focuses on reducing negative consequences of risky or harmful behavior when total prevention of harm is not possible.

Hotspots

Areas where groups of people experiencing street homelessness gather regularly.

Intensive Canvassing

A targeted canvassing effort that can occur in any of the five boroughs. Community associates perform intensive canvassing in high density areas for a specified duration of time.

Language Line

A 24/7 call line that can be used to access a translator for a wide variety of languages.

Motivational Interviewing (MI)

An evidence-based intervention intended to build lasting motivation for change through exploring and resolving ambivalence. Although initially developed to address problem drinking, MI has since been applied to a wide range of populations and behavioral change areas.

Multidisciplinary Approach

Combining or involving multiple disciplines to redefine problems outside of normal boundaries, and reach solutions based on a new understanding of complex situations.

Operations

Core actions taken by the JCC according to determined procedures and workflows.
[Under Development]

Glossary of Terms (continued)

Outreach Team

Non-profit provider staff who work to locate, build relationships with, and offer support to people experiencing homelessness. There are five outreach teams in the City of New York and they cover all five boroughs and the subway system.

Person-Centered Practice / Care

An approach to human services rooted in the empowerment of the individual and a respect for their experiences and choices.

Pop-Ups

Areas where individuals and groups regularly bed down for the night but lack fixed comforts (e.g., furniture, standing structures, curtains, mattresses).

Resilience

The ability to bounce back from adversity, frustration, and misfortune. Resilience helps us survive, recover, and even thrive in the wake of misfortune.

Safe Havens

Programs targeted toward supporting unsheltered homeless individuals, many of whom may be resistant to accepting services. Such programs provide low-barrier transitional settings and specialized supports needed to prepare for permanent housing.

(Source: *The Journey Home: Street Homelessness Action Plan, 2019*)

Social Services

A combination of case management, benefits, and facilities provided by government or non-profit organization intended to improve the lives and living conditions of recipients. Examples include rent subsidies and Medicaid/Medicare.

Stabilization Beds

Stabilization beds are low-threshold private rented rooms for clients experiencing long-term unsheltered homelessness, where clients may stay until they are placed in permanent housing or a long-term transitional setting. Clients must be referred by outreach teams and be able to care for themselves. Case management is provided by outreach teams.

(Source: *The Journey Home: Street Homelessness Action Plan, 2019*)

Street Homeless

Anyone whose overnight residence is in a place that is not meant for human habitation, such as a car, subway station, abandoned building, park, underpass or sidewalk.

Glossary of Terms (continued)

Street Medicine Team

Medical staff who provide medical care on the streets, including blood pressure checks, wound care, vaccinations, etc. May travel in a medical van, which allows more complete medical examinations, evaluations, and blood draws.

Street Sheet

One-page double-sided resource lists that give the location and contact information of services like food pantries, drop-in centers, and hospitals.

StreetSmart

Street Homeless Solutions division case management system and database. Serves as the repository of records for all contracted outreach providers and placement for clients who are experiencing street homelessness.

Strengths-Based Practice / Care

An approach to human services that focuses on strengths, aspirations, experiences, talents, knowledge, and resiliency, rather than perceived deficits or problems.

Trauma-Informed Practice / Care

An approach to human services that considers the pervasive nature of trauma. Avoids practices and services that may inadvertently re-traumatize while promoting environments of healing and recovery.

[\[Further information\]](#)

Vulnerability Index

A tool for identifying and prioritizing the street homeless population for housing according to the fragility of their health. First published in 2007 by James J. O'Connell.

[\[Further information\]](#)

Work Well NYC

A program through the NYC Office of Labor Relations that offers tools, resources, and support for all City employees.

[\[Further information\]](#)