

Safety in Street Medicine Outreach



Introduction

Street medicine is and has been overwhelmingly a safe way to practice medical care. Safety is promoted by including those with lived experience, embodying the core values of street medicine, and incorporating these values into practice. This guideline considers the foundations of safety followed by considerations when getting ready and performing medical outreach.

Foundations of Safety

- Include people with lived experience in developing outreach/safety plans and as core members of outreach.
 - They have invaluable insight and experience both in working with individuals and navigating the physical and psychological environment.
 - Their participation in outreach lowers barriers; builds trust, especially during first encounters; and helps when de-escalation is needed.
- Adhere to core concepts and values that promote honesty, transparency, and authenticity such as patient-led care, trauma-informed care, and harm reduction. For work that especially relates to street mental healthcare, the therapeutic alliance is often the most protective factor for safety.
- Team members should establish boundaries that allow for professionalism and compassionate care without being distant or unrelatable. Team members:
 - Should not be expected to share personal contact information or to work outside of designated hours and settings.
 - Should be mindful of their own emotional capacity to have empathy or sympathy for the people.
 - Should generally not engage in personal relationships, give or receive personal money, or overly share personal information or problems.
- All team members need to complete training and protocols that cover safety topics such as privacy, appropriate conduct while on outreach, and emergency situations.
- Design a protocol for team members to report safety concerns without fear of retaliation and for program administration to address these concerns appropriately.
- Incorporate team wellness to address this rewarding but difficult work that can lead to compassion fatigue and vicarious trauma (especially for those with lived experience).
 - Leaders should prioritize self-care by modeling good self-care and creating a work environment that promotes team bonding and unity, maximizes team and individual efficacy, and minimizes burnout promoting factors such as excessive paperwork and charting.
 - Create an environment of communication and trust between team members so that they can share and build resilience.
 - Have opportunities to mourn loss, celebrate life, and recognize the importance of holding space and humanity that was given by the street medicine team.
 - Offer services in mental health, wellness, and/or resilience-building and managing moral injury.
- This guideline discusses safety generally and cannot encompass details and considerations for the unique needs of specific populations such as intimate partner violence, mental health, queer health, sex work, and trafficking. Consider engaging with those with lived experience and local organizations to further build representation and the community safety net.

Getting Ready

- An ideal outreach team size is 2-4 people including a clinician and peer navigator. Larger teams can be considered for large encampments but can be disruptive/intimidating; consider splitting into smaller teams and dividing roles. Team members should never go on street medicine rounds alone.
- Avoid triggering/disruptive appearances. This can include inflammatory clothing, overly formal clothing, color combinations that imply gang or other affiliations, strongly scented hygiene/cosmetic products, or potentially offensive tattoos. Keep jewelry to a minimum and avoid large or dangling items.
- Preparing for the environment
 - Clothing: Non-slip closed toed shoes (such as waterproof hiking boots) and pants instead of shorts. Consider bringing extra layers of clothing in case of sudden weather changes.
 - Flashlights or head lamps for dark environments or nighttime
 - Layering and protecting face/extremities in cold weather, hydration and breaks in hot weather
 - Appropriate medical personal protective equipment (PPE)
- Consider requiring up-to-date vaccines and having a tuberculosis screening requirement.
- Team members should not bring weapons or pepper spray out on medical outreach.
- Before starting, team members should define roles, discuss plans for the day, and ensure everyone knows the safety plan. Consider adding check-in/check-out procedures with a supervisor or designated contact.

Performing Outreach

Approaching Area

- Announce presence prior to entering a camp or outreach site, e.g. "street medicine!" or name of organization.
- If someone is present, approach from the front and use friendly body language.
- Do not shake or open tents; be invited in.
- Watch for pets and allow the person to calm or leash their pets first. Check with the owner before extending your hand out to a pet or giving the animal any treats.
- Do not wake people who are sleeping unless there is a specific agreed upon need or it is an emergency.
- If it is dark, avoid shining the flashlight or head lamp in the faces of the people.
- Be aware that people who are unsheltered may carry a weapon for their own defense and do not intend to cause harm. Develop guidelines with your team regarding thresholds for the team to exit (e.g. threats, brandishing a weapon, or the presence of firearms). The presence of large knives can be common. Most street medicine teams maintain awareness of knives but only leave the site if someone expresses intent to harm the team or someone else.
- If using a vehicle, consider safe parking and exiting practices as well as securing equipment and supplies when stepping away.

Creating a Safe Space & Situational Awareness

- Involve the patient and agree on a comfortable space for history and examination that is still within sight of other team members.
- Be mindful of others around the patient when discussing sensitive topics.

- Words matter - Avoid stigmatizing words such as “hobo,” “addict,” or “drug abuser” when talking to patients or each other. Do not correct patients or those with lived experience who use stigmatizing words but do educate team members who are in a caring role.
- Have situational awareness by designating a team member to look out for the team. Always maintain visual or verbal contact between team members so that members are not isolated. Be flexible as the environment changes (e.g. weather, crowds, or bad actors).
- Anticipate the need to create a safe/private space when working in a public area such as using team members to create a privacy barrier. The team leader may need to engage members of the public to manage onlookers and curious individuals. If negative public attention escalates, plan for follow up, encourage/help the patient leave, then remove the team from the situation.
- Consider creating guidance on maintaining scene safety and crowd management in emergency situations such as responding to an overdose.

Encountering Violence on Street Rounds

- People who are unsheltered may stay in areas with increased risk of violence. This is often unrelated to the people themselves but due to societal pressures that force them to be less visible. Any location may change or become less safe for periods of time.
- Teams should discuss concerns and actively listen to teammates with lived experience to decide how to address concerns about violence. Consider changing the team size or not taking out guests/visitors to enhance team safety in places the team decides to continue visiting. Team members should not be required to go to locations that they perceive as unsafe, as this affects both the team member and the quality of care being delivered. The whole team may decide to not go to an area for a period of time until situations change.
- Teams may struggle with the choice not to visit an area as it feels like they are abandoning their patients. Keeping the team and patients safe is not abandonment, and there are practices that help people stay connected. Consistently ask patients where else they spend time during the day in case they are relocated in street sweeps or need to be seen in a less violent area. Programs can offer ways to reach the team through phone/text/voicemail, email, or social media; these less secure ways to communicate should not be used to discuss health information, but they can be used to plan where to meet. Finally, teams may ask others sleeping outside to spread word of a new location to connect with services.

If Things Escalate

- Have a safety plan including code words. For example, USC Street Medicine in Los Angeles, California uses the question “Do you have a yellow highlighter?” to indicate to each other that they should wrap up and leave within 3-5 minutes. A “red pen” request tells team members to leave immediately.
- Use de-escalation when it is safe to do so and can help the patient (especially when there is an existing relationship and a peer navigator). Do not force anything and consider returning later; respect “no.”
- When approaching someone in crisis, weigh the benefits/risks of engaging compared to returning later.
- Considerations for calling emergency services (outside of times when it is required):
 - People who are unsheltered often face stigma and trauma from first responders, especially law enforcement. Risks include repeat traumatization, disengagement, and loss of trust of the street medicine team by the person as well as others who are unsheltered. If they already face legal issues, calling emergency services may place them at risk of arrest.
 - Include the patient whenever possible in the decision to call emergency services.
 - Apply harm reduction and person-first principles if the patient does not want emergency services involved in order to continue to support their positive change.

- Do not call for minor illegal acts, e.g. buying street drugs or public urination.
- Do not intervene in a street fight or other violent acts. If it is safe to do so, treat all who are injured and ask those affected if they would like assistance to go to the hospital or file a police report.
- It is discouraged to call for institutionalization for substance use or mental health except when absolutely necessary, e.g. imminent danger to self or others when other means of ensuring safety have been exhausted. Know the applicable laws in your area, what circumstances would meet criteria requiring institutionalization, and think through the risks and benefits of involuntary care.
- Mandatory reporting needs to be done if required but be mindful of the known harms that disproportionately affect vulnerable communities. Consider the repercussions from reporting and how (or if) the street medicine team can mitigate the harms.

Follow-up Plan

- Having a plan ensures continued safe practices until the next visit.
- Work with the patient to create a plan together including a way to contact the street medicine team.
- Clearly and compassionately explain rationale for involuntary interventions if used.

Create a culture of reflective practice after each street round.

- A safe place/moment to discuss outreach without retribution or blame
- Allows sharing of both positives and chances for improvement
- Should be voluntary for team members

Conclusion

Safety in street medicine relies on building a culture of practice based on a foundation of core values that guide positive and safety-minded actions throughout the encounter. It is invaluable to include people with lived experience in every step of building a safety plan. Incorporating good outreach safety practices will prevent harm to the patients and the team during outreach and increase the chance of successfully providing care.

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References/Additional Reading

- Becerra, J., Turner, A. (2024, June 10). *Safety and De-escalation techniques on the street* [Webinar]. New Mexico Street Medicine ECHO. <https://iecho.org/batch/BCH16935156972533FJUN2CZCF?tab=schedule&sessionId=SES16935156987640KK7058U8K>
- Bennett, M. (2016, October 5). *Being Trauma-Informed and Its Role in Ending Homelessness* [Webinar]. National Health Care for the Homeless Council. <https://nhchc.org/resource/being-trauma-informed-and-its-role-in-ending-homelessness/>
- Hatcher, S., Frye, L., Van Herk, K. (2025). Trauma Informed Care. In *Street Mental Health Handbook: Care Delivery Across the Spectrum of Homelessness* (pp. 13-19). Springer.
- Homelessness Learning Hub. (2020). *Trauma-Informed Care*. <https://homelessnesslearninghub.ca/learning-materials/trauma-informed-care/>
- Feldman, B.J., Becerra, J. (2022, January 20). *Promoting Safety in Street Outreach* [Webinar]. National Health Care for the Homeless Council. <https://nhchc.org/resource/promoting-safety-in-street-outreach/>
- Mandatory Reporting is Not Neutral. <https://www.mandatoryreportingisnotneutral.com/>
- Moore, M., Becerra, J. (2024, May 13-16). *Safety Top 10: A Short List for Staying Safe on the Street* [Conference presentation]. National Health Care for the Homeless Council HCH2024, Phoenix, AZ, United States. <https://nhchc.org/wp-content/uploads/2024/06/HCH-Safety-Top-10.pdf>
- National Harm Reduction Coalition. (2024). *Homelessness and Harm Reduction*. <https://harmreduction.org/issues/harm-reduction-basics/homelessness-harm-reduction-facts/>
- National Health Care for the Homeless Council. (2023, November 25). *S and S - Principles of De-escalation* [Online course]. <https://nhchc.org/resource/s-and-s-principles-of-de-escalation/>
- National Health Care for the Homeless Council. (2021, November 16). *Tips to Ensure Safety in Street Outreach. Insights from the HCH Helpdesk*. <https://nhchc.org/tips-to-ensure-safety-in-street-outreach/>
- National Institute on Drug Abuse (NIDA). (2021, November 29). *Words Matter: Terms to Use and Avoid When Talking About Addiction*. https://www.asam.org/docs/default-source/default-document-library/nidamed_wordsmatter3_508.pdf?sfvrsn=5cf550c2_2
- National Law Center on Homelessness & Poverty. (2018). *Housing Not Handcuffs: Ending the Criminalization of Homelessness in U.S. Cities*. <https://homelesslaw.org/wp-content/uploads/2018/10/Housing-Not-Handcuffs.pdf>
- Thompson, M. (2024, July 23). *The Role of Law Enforcement in Homelessness Response*. National Alliance to End Homelessness. <https://endhomelessness.org/blog/the-role-of-law-enforcement-in-homelessness-response/>
- Withers, J. S., & Kotov, E. (2021). How Should Street Medicine Clinicians Interact With Law Enforcement Officers? *AMA Journal of Ethics*, 23(11), E881–E886. <https://doi.org/10.1001/amajethics.2021.881>