Orientation to PATH Outreach for New Staff (Session #1)

FEBRUARY 8, 2022

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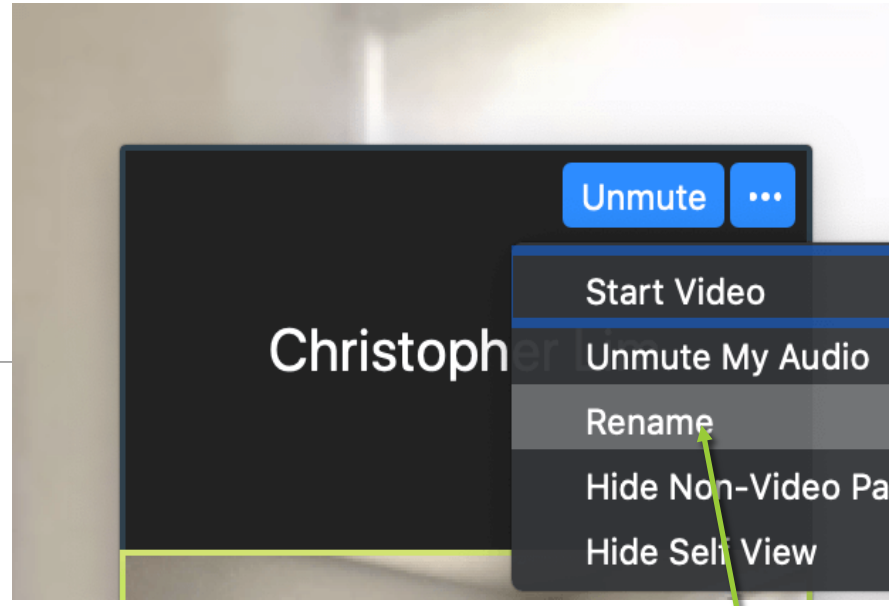
Welcome



- Introduce CT DMHAS Staff and Facilitators
- Goals for the Session
- Housekeeping
  - **PLEASE TURN YOUR CAMERAS ON AS MUCH AS YOU CAN**
  - **Please put your name as you would like to be addressed as your screen name**
  - **We will upload the slides to the chat box momentarily**
  - **We love interaction – please raise hand, use emojis, type comments in the chat box or just unmute and talk!**
  - **The session is being recorded and will be posted to the web**
  - **There are more slides and details in this presentation than we can cover in the allotted time, so some slides are for reference.**

Ice Breaker

Please put in the chat box:

- Your agency and role/title
- Your location
- Your favorite winter activity

- Welcome & Introductions
- Outreach Overview: Values, Vision, Goals, Outcomes & Outreach Worker Roles
- Engaging the Target Population
- Housing First & Housing Focused Case Management
- Documentation & Administrative Responsibilities
- Key Partners
- Closing Comments
- Additional Resources

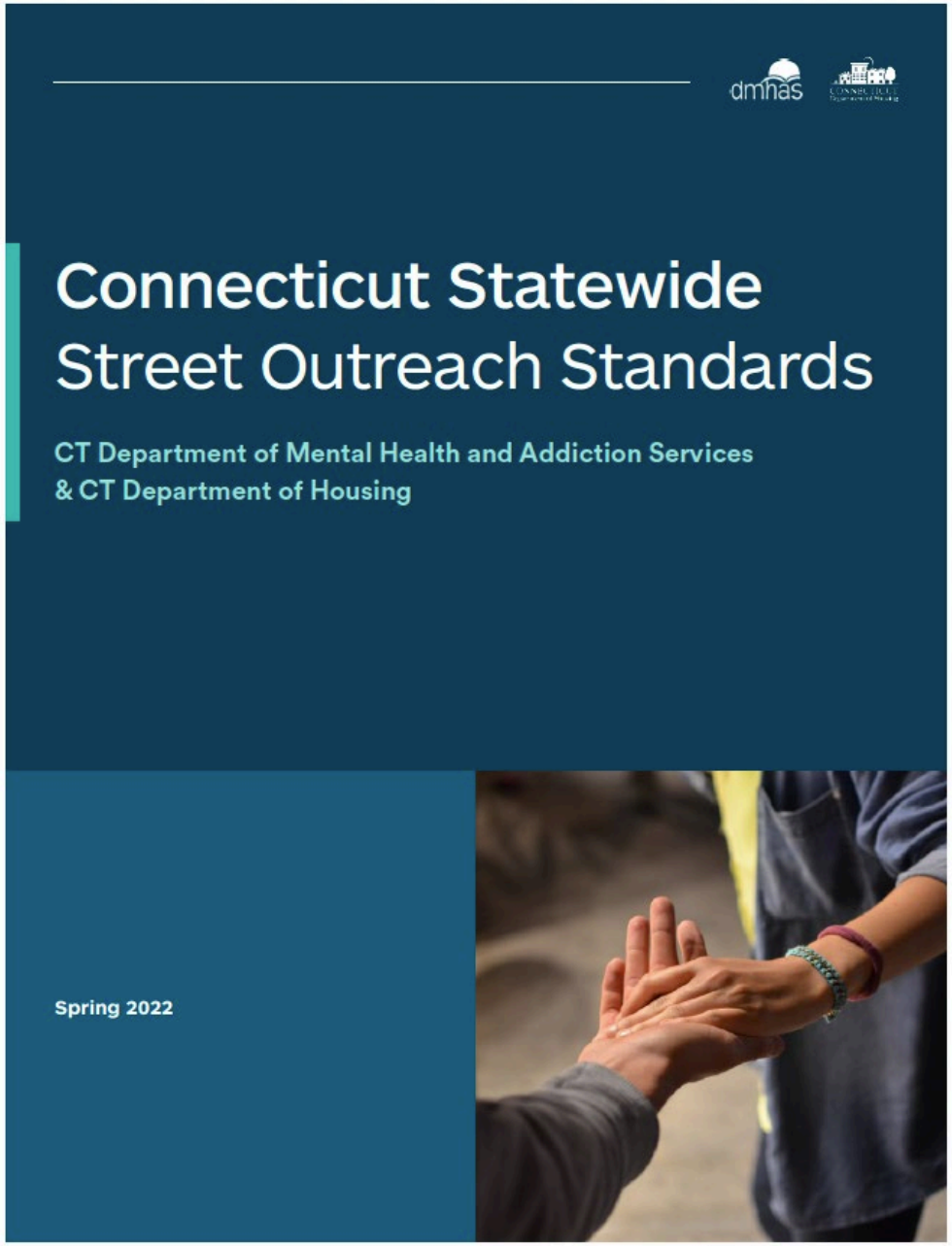
Zoom Polls

How long have you been in your current position?

How much experience do you have in street outreach work?

Outreach Overview

VALUES, VISIONS, GOALS
OUTCOMES & OUTREACH
WORKER ROLES



March 2022: Document Release Anticipated

TBD: Contract Implementation Date

CT State Outreach Values

- Housing First
- Urgency – end homelessness as quickly as possible
- Respect perspectives, motivations, choices & property
- Build trusted relationships with clients & partners
- Minimize risk & reduce harm
- Create equal access
- Create transparency with clients and partners
- Be consistent

CT State Outreach Values (2)

- Become allies in clients' journeys
- Engage as an interdependent provider in a network of committed service providers
- Practice & support culture of self-care
- Meet people where they are
- Be flexible & creative problem-solvers
- Commit to data & documentation – use in collaboration & service improvement
- Rigorously plan outreach

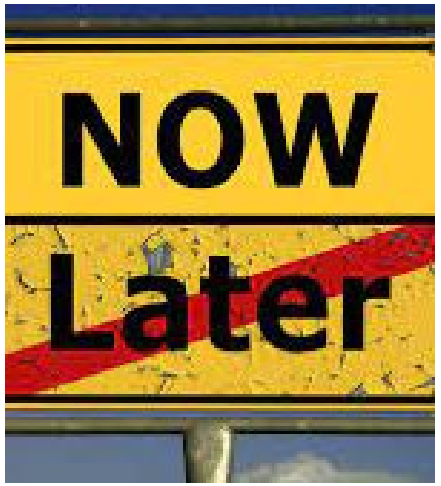
CT Outreach Vision and Goals

Vision: to support people experiencing unsheltered homelessness in achieving some form of permanent, sustainable housing

Goals:

1. Quickly connect to safe housing, income & other supports
2. Identify people living in unsheltered locations
3. Minimize service gaps or duplication
4. Use resources strategically to end homelessness
5. Prepare & support people to meet tenancy obligations
6. Provide warm handoff and aftercare

CT State Outreach Outcomes



Unsheltered clients, especially most vulnerable, **move into housing**

- % of clients exiting outreach to a permanent housing location
- % of clients on high priority list exiting outreach to a permanent housing location

Clients' experience of homelessness **not one day longer** than necessary

- % of referrals from 211/community partners contacted within 24 hours or due diligence to locate documented
- For clients who exited to permanent housing, length of time from outreach enrollment to move-in

CT State Outreach Outcomes (2)

Clients get supports in **harm reduction** and **tenancy preparation**

- % of clients with increased income from enrollment to exit
- % of contacts for whom documentation demonstrates info provided on resources/services

Outreach projects within the same geography **minimize service gaps and duplication**

- % of unsheltered persons encountered entered into HMIS within 72 hours
- % of enrolled clients with complete HMIS records

Newly housed clients get **support to adjust to new surroundings**

- % of clients with a housing move-in date for whom HMIS record shows continued outreach enrollment and check-ins for 90 days

Key Responsibilities of Outreach Workers

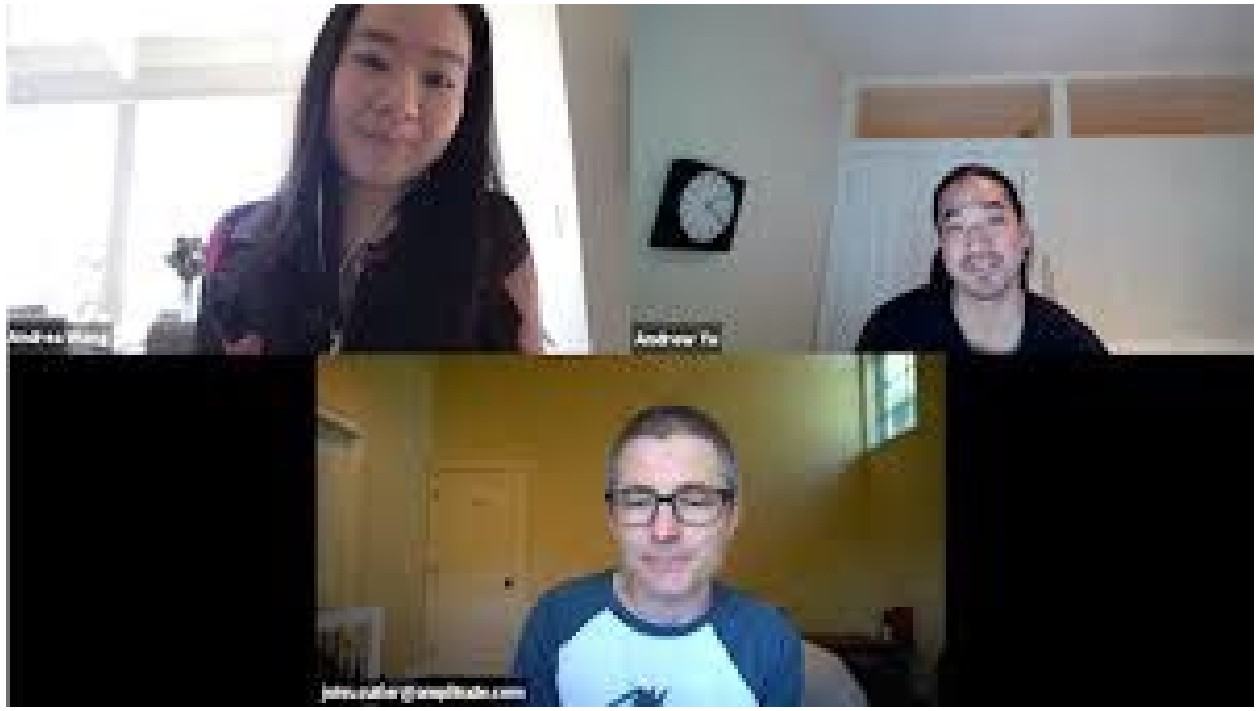
- Identify who is living unsheltered in your assigned geographic area
  - Includes: canvassing, maintaining partnerships, responding to referrals, may include in-reach
- Make contact and establish credibility and relationships with people living unsheltered
  - Includes: earning trust, being consistent and reliable, demonstrating kindness and helpfulness
- Collect and enter data
  - Includes: entering prompt, accurate data into HMIS, may also include responsibility for DDAP upload

Key Responsibilities of Outreach Workers (2)

- Provide housing-focused case management
  - Includes: Assessing client needs and developing housing/service plans
- Coordinating with partners to move clients into housing
  - Includes: Participating in the CAN, helping clients to understand housing options and access other essential services, providing after-care, and warm-handoffs

Break Out Discussion –Groups of Three

1. What led you to apply for your current position?
2. How would you like to contribute towards realizing the CT Street Outreach Vision?



Learn More About CT Statewide Outreach Standards

3/15/22 Quarterly Outreach Meeting

1pm – 2pm

Join on your computer or mobile app

Click here to join the meeting

Or call in (audio only)

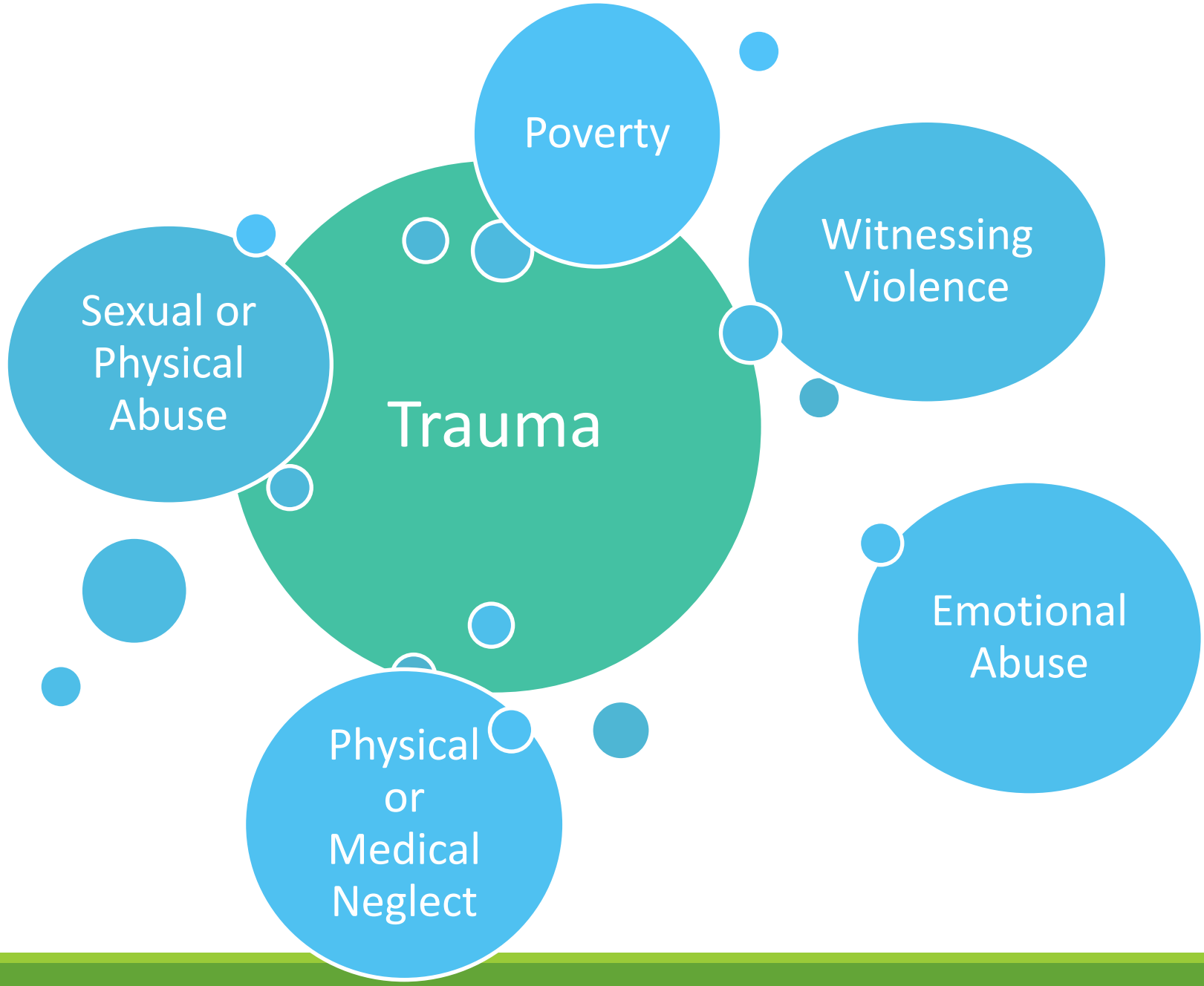
+1 860-840-2075

Phone Conference ID: 977 337 691#

Engaging the Target Population

Day One: Develop a relationship with clients

Primary Goal: Create a “why” for the person to engage with you.


Poverty
Witnessing Violence
Sexual or Physical Abuse
Trauma
Emotional Abuse
Physical or Medical Neglect

Trauma & Homelessness

People experiencing homelessness are likely to have experienced & continue to experience some form of trauma, which can interfere with:

- Sense of safety
- Perception of control and self-efficacy
- Interpersonal relationships & ability to self-regulate

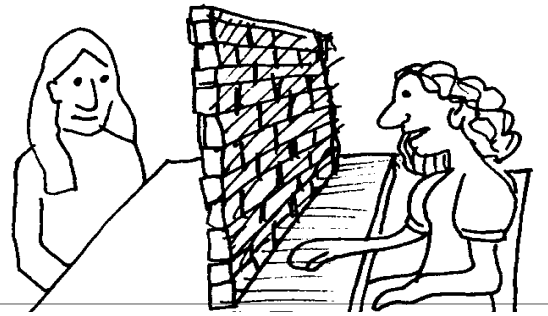
Trauma-Informed Care Examples:

- Emphasize safety & be predictable
- Emphasize client choice & rebuild control
- Be aware of triggers and avoid re-traumatization
- Assist to identify strengths and build skills

Building the Relationship

- Be yourself. People know if you are being authentic.
- Keep showing up and always follow through promptly.
- Listen to identify what the person wants and cares about.
- Be patient and don’t push any agenda.
- Start with small goals and keep it simple.
- Provide concrete assistance: food, clothing, gear, hygiene & COVID supplies, documents.
- Offer as many choices as possible and talk about opportunities.
- Build confidence and trust as you accomplish things together.
- Provide relief
- Ask for help: Clinical consultation can help determine what is underlying what you are seeing and plan the best approach.
- Seek information: client, CAN, HMIS, EMS, police, mainstream and homeless service providers

Barriers to Engagement



BARRIERS

- ❑ Psychosis – delusions, hallucinations, paranoia
- ❑ Inebriation
- ❑ Irritability/agitation
- ❑ Disorganization
- ❑ Moving locations
- ❑ Mistrust of worker
- ❑ Worker not showing up or following through
- ❑ Others?

CAUSES

- ❑ Mental Illness
- ❑ Substance Use
- ❑ Trauma and PTSD
- ❑ Traumatic Brain Injuries/Strokes
- ❑ Cognitive Impairments
- ❑ Bad experiences with services
- ❑ Others?

Maintaining a Client-Centered Approach

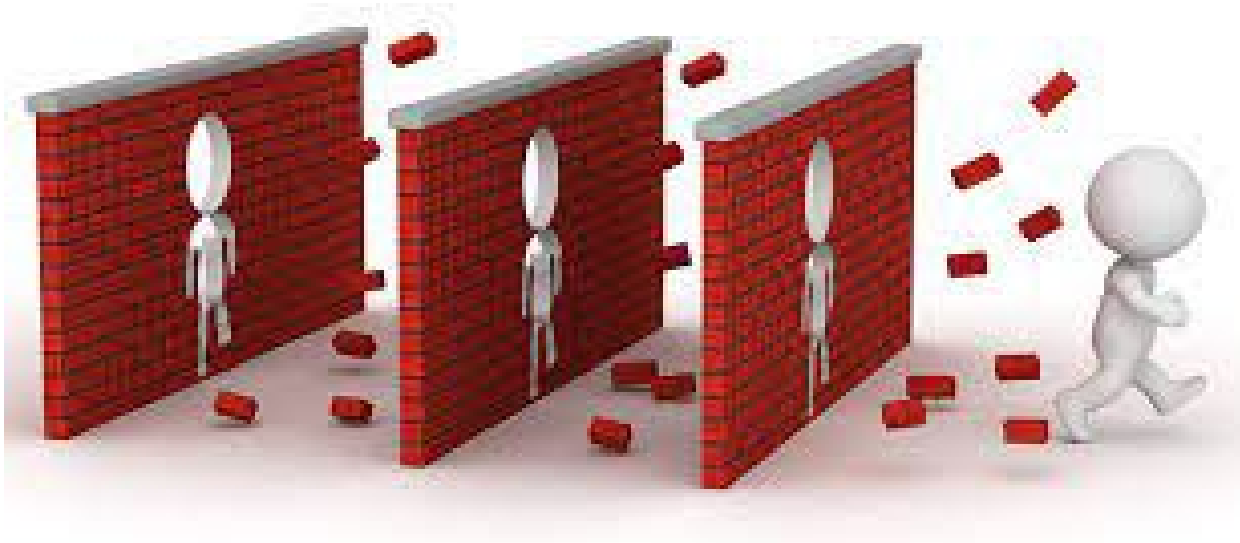
- Offer services multiple times and in different ways.
- Understand client perspectives, including any reasons they are not using shelter/services.
- Help clients solve the problems that are most important to them.
- Advocate with community partners to make sure clients get the services they need and that services are working for them.
- Assist in accessing temporary accommodations and permanent housing that can accommodate the entire family, including pets

Break Out Discussion

Groups of Five

Discuss a client whom you have had trouble engaging in services.

- What are the engagement barriers?
- How did or might you overcome those barriers?



Contacts and Enrollments

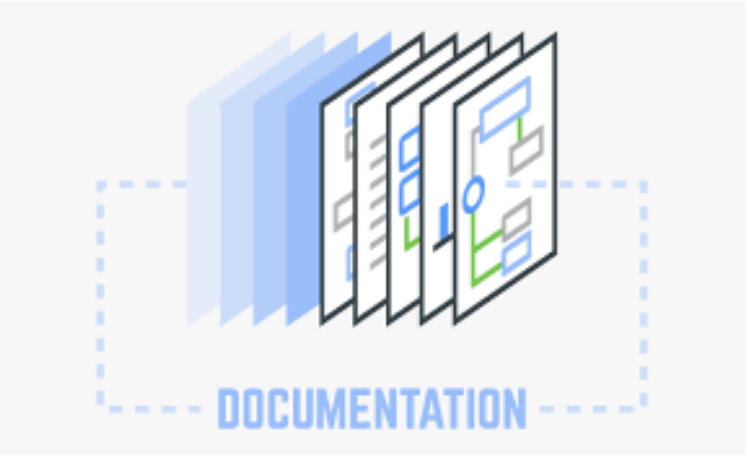
Contact: Person experiencing homelessness encountered by an outreach worker whom you attempted to engage or whom you provided information or referral(s)

Enrollment: PATH eligible person entered into a PATH project in HMIS.

Only people determined or suspected to be experiencing Serious Mental Illness (SMI) are eligible for enrollment in PATH projects.

- SAMHSA definition: *"Serious mental illness is defined by someone over 18 having (within the past year) a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities."*

Documenting Serious Mental Illness (SMI)



Evidence of SMI can include:

- Disability Verification that specifies an SMI;
  - ✓ *Until a DV is obtained, document attempts to obtain*
- A standard mental health screening instrument that suggests that the client should be referred for further assessment for SMI. See below for additional guidance on one such tool (i.e., the Modified Mini Screen); or
- Case notes that document observation by an outreach worker of possible mental health symptoms and/or collateral information from another service provider accompanied by consultation with a clinician indicating that the client should be referred for further assessment for SMI.

Guidance on Documenting SMI

Modified Mini Screen PATH Outreach Worker Training

Wednesday, February 16, 1 – 2:30 p.m.

Join Zoom Meeting
Meeting ID: 886 9700 2348
Passcode: 667293
Phone: 646 876 9923

Webinar: Working with People with Mental Illness

Presentation slides: Working with people with mental illness

Recording: https://youtu.be/7qzCbGe0rHc

Safety

Safety During Street Outreach

- Be sure someone at the office knows your field schedule, including locations and times – check in on a predictable schedule.
- Follow your agency's safety protocols.
- Remember you are in the clients' space.
- Know when not to attempt to engage and when to walk away, including when sex/drugs are being sold.
- Schedule outreach in pairs whenever possible & always in high-risk situations.
- Leave non-essential valuables behind.
- Dress comfortably in shoes that you can easily walk/jog in.
- Get help if a crisis emerges – know how long it will take help to arrive and plan accordingly.

Safety During Street Outreach

Plan Ahead:

- Always have charged phone accessible.
- Maintain a clear exit path – don't go places without a viable exit.
- Negotiate visits in advance if possible - be clear about conditions (e.g., intoxication, firearms, aggressive pets).
- Consider scheduling in early a.m. when intoxication is less likely.
- Learn about any client history of dangerous behavior.
- Build a partnership with local police.

Look Back:

- Follow your agency's incident reporting policies and use incidents as an opportunity to learn.

Learn about De-Escalation Methods

Resources:

Crisis Prevention Institute | www.crisisprevention.com

Assertive Communication: De-Escalation | https://thousandwaves.org/self-defense/resources/

The Center for Nonviolent Communication | www.cnvc.org

Quality Behavioral Solutions | www.qbscompanies.org

Harm Reduction

Accept clients' priorities and choices as a matter of fact without judgment.

Help client to identify personal goals and preferred paths to achieve.

Raise awareness of options, risks and strategies to reduce harm.

Intervene, as necessary, when someone presents an imminent risk of danger to self or others.

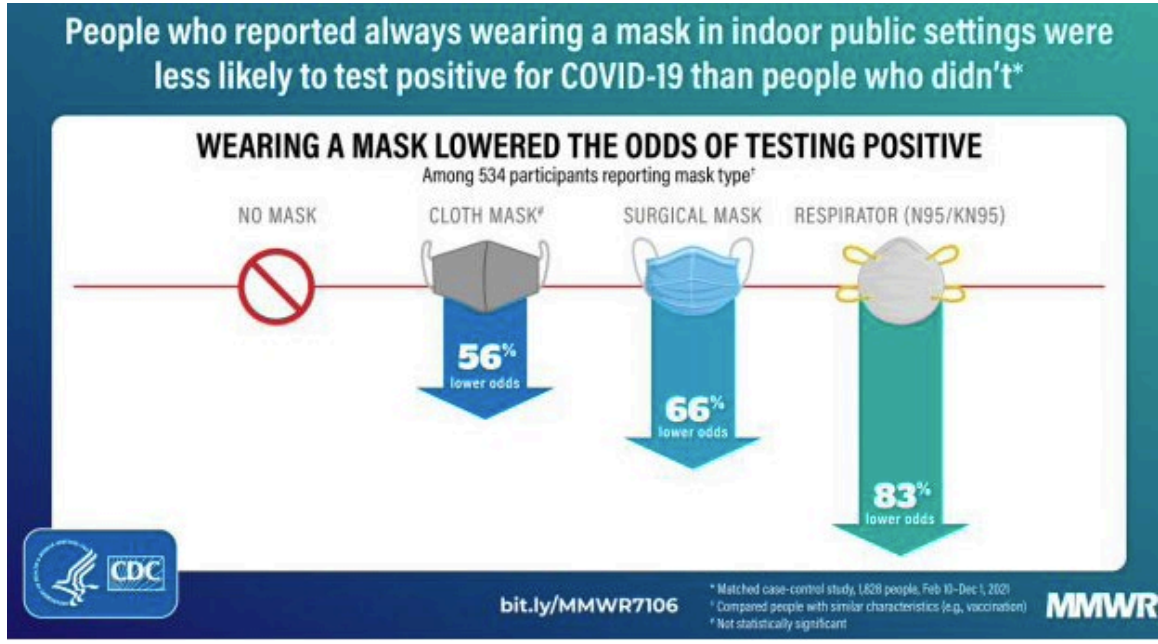
Harm Reduction Plan - PDF

COVID Staff Safety During Outreach

Follow your agency's guidelines.

CDC current guidance:

- Vaccination is recommended for all staff
- All staff
  - Wash hands or use hand sanitizer regularly
  - Avoid handling client belongings
  - Stay home if you are sick
- Unvaccinated staff
  - Maintain 6 feet distance when interacting
  - Wear masks when working in public settings or interacting with clients



Source: CDC website – Unsheltered Homelessness Page

COVID Client Safety During Outreach

- Provide information regarding vaccinations and help facilitate when possible
- Provide masks and hand sanitizer for clients
- Encourage frequent hand washing
- Assist to access toilet/shower facilities
- Assist to obtain Narcan and medications
- Coordinate discharges from correctional/health care settings
- Screen for COVID-19 symptoms
- Continue linkages to housing and additional supportive services

1)What strategies does your project use to keep outreach workers safe always and during COVID?

2) Any new strategies you'd like to implement?

PUT RESPONSES IN CHAT

CT COVID-19 Tool Box

Includes:

- Find a vaccination site
- Find a no-cost testing site
- Daily DPH Van Clinic Schedule
- How to host a DPH Van

Housing First and Housing-Focused Case Management

Housing First

Everyone is ready for housing, regardless of the complexity or severity of their needs. Services post housing support stability and prevent returns to homelessness.

Housing First Best Practices

- Assertive engagement using motivational techniques
- Comprehensive assessment and housing planning
- Harm reduction/recovery oriented
- Links to Community Supports: social, spiritual, libraries, sports, arts, recreation
- Individualized and person-centered

Service Planning Process

For clients receiving full case management:

- Complete within 30 days of enrollment
- Update at least every 6 months

Sample PATH Assessment and Service Plan Template

Needs Assessment

- Is a process
- Requires trust that offering information will lead to needed services/resources
- Information unfolds over time.
- As client experiences challenges and progress, assessment will deepen.

Understand Housing and Homeless History

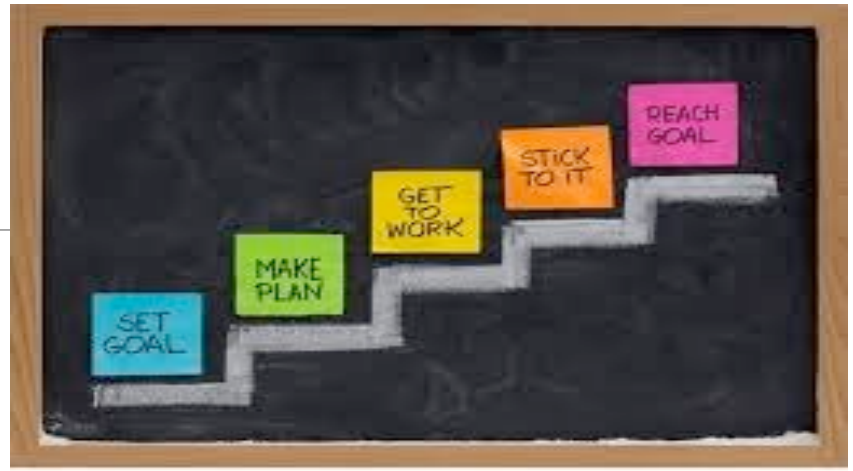
Housing History –

- Places lived, with whom (last 5 years)
- Experience as a leaseholder
- What worked
- What didn't

Homelessness History -

- Cause of initial episode
- Length of time homeless
- Places stayed
- Routine & Role
- Supports

Service Planning



- Guides and provides structure for the work.
- Goals focused on what matters to the client.
  - "So that" principle. I want x so that y happens
- Makes progress manageable by breaking out small steps.
- Requires on-going assessment - Informed by discussions with client, team, informal supports & community resources.
- Evolves over time.
- Builds hope and a sense of accomplishment as objectives are achieved.
- **Type in the Chat Box some of the goals you are working on with people.**

Building Motivation for Change: Hope, Meaning and Confidence

HOPE	• How can you change if you don't think it is possible?
MEANING	• How can you change if you don't think it is important?
CONFIDENCE	• How can you change if you don't think you can do it?

Assessment and Service Planning Webinar

Presentation Slides: PATH Assessment and Planning - PDF

Recording: https://youtu.be/-Wx7Kxkfa7g

Accessing a Temporary Place to Stay

What are the options?

Shelter/Hotel/Motel?

Doubling up with friends/family?

What are the responsibilities?

How does it connect to what the client wants?

Housing Navigation

Choices that may be available:

- Rapid Re-Housing
- Permanent Supportive Housing
- Market Rate Rentals and Low-income Tax Credit Buildings
- Shared Housing
- Subsidized Housing such as Housing Authority Properties

Help clients to explore:

- What they are eligible for
- What is the waiting time for each?
- What are the expectations in each?
- What are their individual preferences and non-negotiables?
- How do available options connect to long-term aspirations?

Sample framework for helping clients to evaluate housing options

Housing Preferences Worksheet - DOC

Webinar: Helping Clients to Understand Housing Options

Presentation slides:

Understanding Housing Options – PDF

Webinar recording:

https://youtu.be/NI_8EzpHEv4

Support During Housing Application & Move-In Process

- Participate in CAN Case Conferencing and Matching meetings
- Prepare and support clients for success:
  - Teach tenancy rights and responsibilities.
  - Anticipate housing stability risks and help clients establish plans to mitigate risks.
  - Assist to set up the apartment to feel like home.
  - Help plan how client will structure their initial days in housing.
  - Make at least monthly contact attempts after move-in for at least 90 days

Supporting Transition to Housing

- Opportunity for change and a new start
- Both loss and gain
- Can increase symptoms
- Involves moving into the unknown
- Requires a new daily schedule
- Sometimes triggers fears of failure

Warm Hand-offs

- Leverage outreach workers' deep ties.
- Accompany clients to appointments with new service providers whenever possible.
- Provide follow-up support on a gradually declining basis to both new staff and the client.

Income Assistance - Benefits & Employment

- Screen for public benefits eligibility and assist in applying for benefits.
- Screen for military service and connect to the VA.
- Accompany to appointments whenever possible.
- Help increase income through meaningful goal setting, breaking down steps into manageable pieces.
- Explore formal and informal work (e.g., sweeping up, lawn mowing, snow removal, day labor).

Income and Benefit Sources

Sources of Income & Benefits:

- CT Dept. of Social Services
  - Connect CT: See if you may be eligible for medical benefits, help buying food, and/or cash assistance, apply for benefits, access your account

SSI/SSDI Outreach, Access, and Recovery (SOAR) – increases access to benefits for those eligible who are experiencing or at risk of homelessness, and have SMI, and/or co-occurring substance use disorder.

- Employment Resources

Didn't Get Three Economic Income Payments (EIP)or Got Less than Full Amount?

- Recovery Rebate Credit
- Must file a tax return, even if you aren't required to file.
- Free Tax Filing Services: VITA

Zoom Poll: Which services is your outreach program providing? Which approaches are you using? Which could use more attention?

SELECT ALL THAT APPLY.

Documentation & Other Responsibilities

Respecting Clients' Rights

Adhere to **confidentiality** requirements:

- During discussions with clients, colleagues, collateral contacts
- Obtain a signed release of information to authorize disclosures
- Obtain an HMIS release to authorize data entry
- Ensure written records are properly stored

Inform clients of the right to use your agency's **grievance** process

For more information see:

- Your agency's confidentiality policy and procedure
- Your agency's grievance policy and procedure

Why is documentation important?

- To ensure no one falls through the cracks and everyone has someone checking in with them.
- To establish an agreement about what you are working on together and what you are going to do by when.
- To track what you agreed to do & ensure it's done promptly.
- To ensure every person is prioritized and connected to housing as quickly as possible & to inform continuous quality improvement.
- To conserve scarce resources and avoid service duplication.
- So other people can find your clients, know something about them and what you were working on together in case you cannot continue to provide services.

Administrative Requirements & Resources

- HMIS Data Entry
  - HMIS Outreach Documents and Files
  - HMIS Help Desk: help@nutmegit.com
  - HMIS Training
  - Outreach Program Performance Data
- DMHAS's data system (DDaP): PATH data must be uploaded to DDaP
  - Ensure staff complete DDaP training & can run reports
  - Agency progress reports posted quarterly
- Providers must submit the PATH Annual Report (PAR) through the PATH Data Exchange (PDX) – typically October - https://pathpdx.samhsa.gov/
  - For questions related to PDX : pathpdx@samhsa.hhs.gov.

Point-In-Time (PIT) Count

- DMHAS requires PATH projects to participate in the annual PIT count of people experiencing unsheltered homelessness.
- Advancing CT Together (ACT) PIT Home Page

Key Partners

Key Partners List

- Substance Abuse and Mental Health Services Administration (SAMHSA)
- Department of Mental Health and Addiction Services (DMHAS)
- Coordinated Access Networks (CANS)
- PATH Outreach Providers
- Department of Housing (DOH)
- DOH Funded Outreach Providers
- Connecticut Coalition to End Homelessness (CCEH)
- Nutmeg Consulting
- Housing Innovations (HI)

Key Partners
SAMHSA & DMHAS

Substance Abuse and Mental Health Services Administration (SAMHSA)

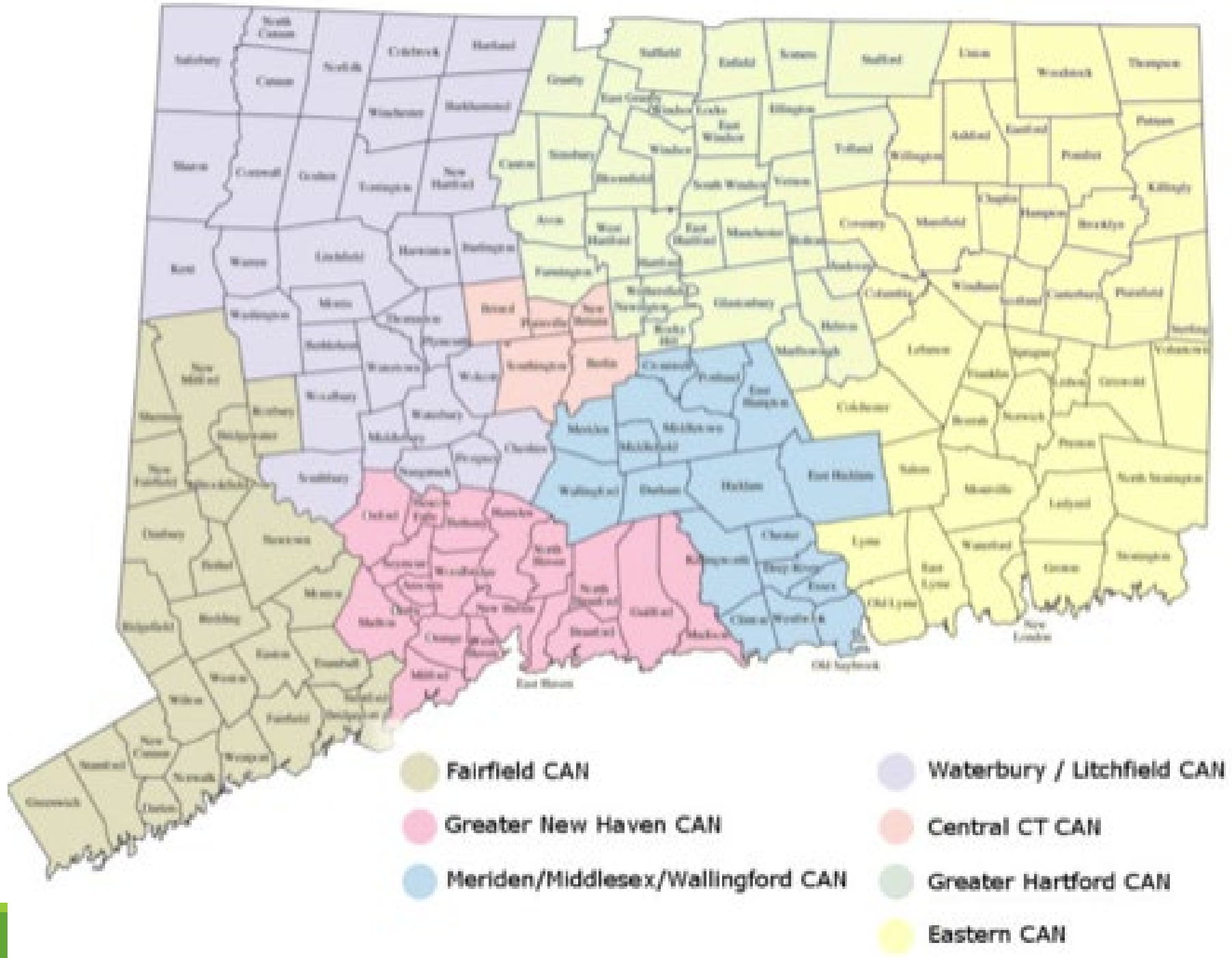
- Provides PATH funding to DMHAS
- Establishes federal requirements & requires states to monitor
- Administers PDX

CT Department of Mental Health and Addiction Services (DMHAS)

- Administers PATH funds in CT
- Provides behavioral health services and housing
- Establishes state requirements and monitors adherence
- Administers DDaP

Key Partners – Coordinated Access Networks (CANs)

- Coordinate access to homelessness assistance
- Ensure standardized assessments, referrals and prioritization for housing
- Maintain the By Name List
- CAN Administrator Contact Info
- CAN Policies


Fairfield CAN
Greater New Haven CAN
Meriden/Middlesex/Wallingford CAN
Waterbury / Litchfield CAN
Central CT CAN
Greater Hartford CAN
Eastern CAN

Key Partners – PATH Outreach Providers

Catholic Charities of Fairfield County (CCFC) – Fairfield County CAN - Bridgeport
- Open Doors - Norwalk
- Pacific House - Stamford

CHR– Greater Hartford CAN

Center for Human Development (CHD) – Northwest CAN

Reliance Health – Eastern CAN - Norwich
- New London Homeless Hospitality Center (NLHHC)

Perception Programs, Inc. – Eastern CAN - Willimantic

Friendship Service Center – Central CAN

Columbus House, Inc – Greater New Haven & Meriden/Middlesex/Wallingford CANs
- BH Care – Valley & Shoreline

Key Partners - DOH

- Staffs Coordinated Access Networks (CANs)
- Funds 211
- Oversees shelter, Rapid Re-Housing (RRH) and Youth Homelessness Demonstration Project (YHDP)
- Provides Housing Choice & Moving-On Vouchers & other Affordable Housing Options
- Administers UniteCT emergency rental assistance program
- Funds outreach

Key Partners – DOH Funded Outreach

By CAN Region:

Central: St. Vincent DePaul, Bristol

Eastern: Reliance Health, Inc.

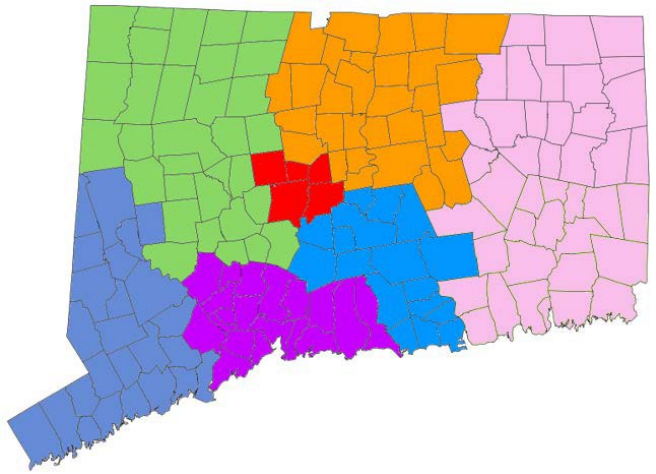
Fairfield: Pacific House

Greater Hartford: Journey Home

Greater New Haven: Liberty Community Services

Middlesex/Meriden/Wallingford: Columbus House

Northwest: Mental Health CT



Key Partners - Connecticut Coalition to End Homelessness (CCEH)

- Homeless Management Information Systems (HMIS) Lead Agency for CT
- Provides research & analysis on CT homeless data
- Provides advocacy & community connections
- Provides education & networking opportunities
- Offers emergency assistance through direct service providers throughout CT

Key Partners & Data Systems – Nutmeg Consulting

- Supports HMIS throughout CT
- Provides Trainings & How-To Instructions on CT's HMIS database
- Staffs the CT HMIS help desk: help@nutmegit.com
- Manages the Point In Time (PIT) Database

Key Partners – Housing Innovations

Housing Innovations (HI)

- Provides PATH trainings and technical assistance
- Provides support to DMHAS and DOH on development of statewide outreach standards
- Monitors PATH Projects on Behalf of DMHAS
- Provides Support to CT Balance of State Continuum of Care (CT BOS CoC)

Closing Comments

Closing

- Building trusted relationships with clients is the foundation of outreach work and permanent housing is the primary goal.
- Housing First eliminates barriers to housing access & emphasizes the supports needed to maintain housing.
- Meet clients where they are and help them get to where they want to be using Housing-Focused Case Management.
- Rely on and be an active participant in a network of service providers.
- Use data and documentation to collaborate and continuously improve services.
- Good luck with this very important work!

Additional Resources

DMHAS/DOH Quarterly Outreach Meetings

Next Meeting: 3/15/22 1pm – 2pm

Join on your computer or mobile app

Click here to join the meeting

Or call in (audio only)

+1 860-840-2075

Phone Conference ID: 977 337 691#

Monthly Community of Practice – Case Conferencing

- 2 groups divided geographically (Cohort A: Second Thurs at 1pm; Cohort B: Second Fridays at 10am)
- Prior to each session, HI will send out an agenda with the topic, questions to start the discussion, and a case conferencing outline.
- In advance think of someone you want to discuss who has either overcome or is struggling with the issue of the month.
- At the end of each session, group will prioritize the topic for the following month.
- All staff are invited. DMHAS requests that supervisors attend with staff.

Outreach Training Resources

- Housing Location & Stabilization
- Working with People with Mental Illness
- Assessment and Service Planning
- Working with People in Hotels
- Expectations in Housing
- Helping Program Participants to Understand Housing Options

COVID Outreach Training Resources

Outreach and PATH section includes links to:

- National Best Practices and Resources
- Webinar recordings & slides from the beginning of the pandemic with topics such as:
  - Mental Health First Aid
  - Harm Reduction
  - Self Care & Support for Caregivers
  - Safety & Symptom Screening

Contact Info

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Questions?