

# CT Outreach (OR) Training

## Best Practices in Outreach to Homeless People

### *Session #2: Housing-Focused Case Management*

MARCH 17, 2026

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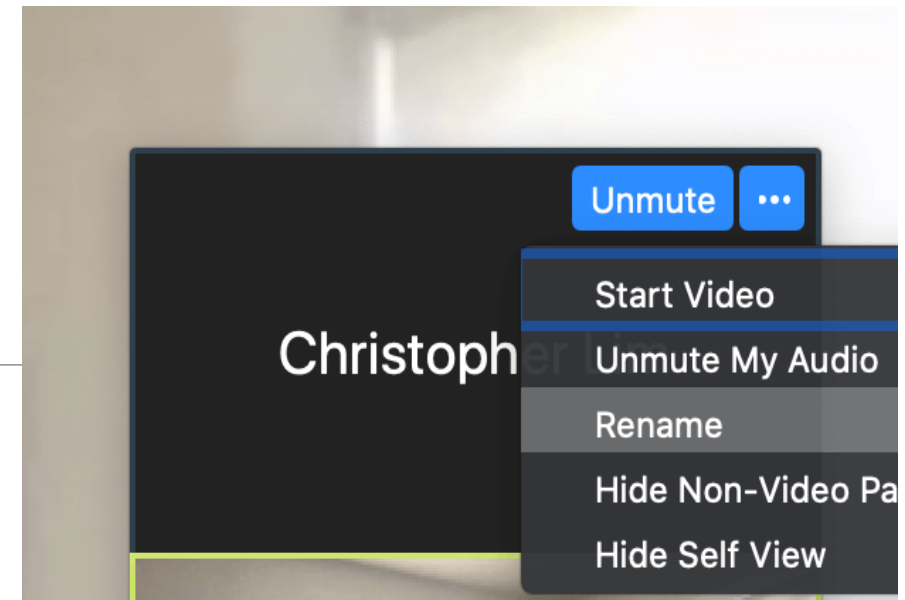
Suzanne Wagner & Andrea White  
Housing Innovations



# Welcome

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- Introduce 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.**
  - **Today's session is 2 hours- some slides are for reference.**



A group of people are seated around a long table in a meeting room, engaged in discussion. The room is filled with people, some looking towards the camera and others looking at each other. There are water bottles, papers, and a tablet on the table. The background shows more people and a yellow wall.

# We Love Interaction

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If you don't have a microphone, participate in discussions by joining via phone:

- Phone: 646-876-9923
- Meeting ID: 844 5428 2209
- Passcode: 185525



# Who is here today?

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**Please put in the chat box:**

- Your agency and role/title
- Your location
- Your favorite ice cream flavor or alternate treat if you don't like ice cream

# Zoom Polls

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How long have you been in your current position?

How much experience do you have in street outreach work?



# Recap Session 1

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- Reviewed Outreach Standards
  - CT Statewide Street Outreach Standards
  - Values, Vision and Goals
- Engagement Strategies
- Client-Centered Relationships
- Reviewed Tools/Checklists available in the Standards
  - After the first contact
  - In between meetings



# AGENDA

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- Welcome & Introductions
- *Strategies to Achieve Outcomes:*
  - *Housing-Focused Case Management*
    - *Building Motivation, Assessment, Goal-Setting and Service Planning*
    - *Coordination with Partners and Community Resources*
    - *Coming Inside and Accessing Housing*
    - *Client Support Through Move-In*
- Closing Comments
- Additional Resources

# Housing Focus in Street Outreach

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*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-Focused Case Management Best Practices

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- Assertive engagement using motivational techniques
- Comprehensive assessment and housing planning
- Participant-driven goals
- Wellness approach that is recovery oriented
- Links to Community Supports: income and benefits, health and behavioral health services, social connections, faith community, libraries, sports, arts, recreation
- Individualized, goal-based and person-centered



# Building Motivation for Change: Hope, Meaning and Confidence

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## 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?

# Break Out Discussion

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Introduce yourselves to one another

Share strategies you have used to:

- Build a client's confidence
- Made progress with a person who has given up hope or said they have no goals
- Build motivation for housing



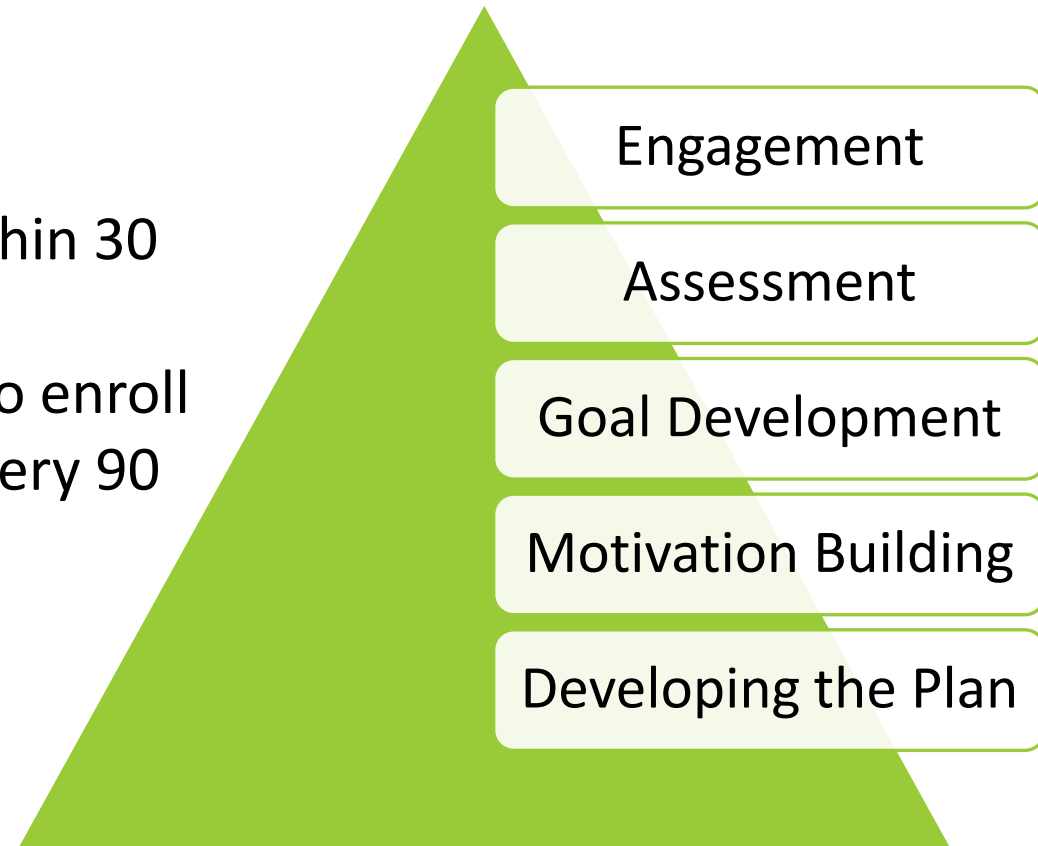
# Service Planning Process

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- Requirements:
  - Once people are ENROLLED
    - Complete service plans within 30 days of enrollment
    - Have guidelines for when to enroll
    - Update the plan at least every 90 days

## **Tools:**

- [Assessment and Service Plan Template](#)
- [Completed Sample](#)



# Needs Assessment

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- 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.
- Listen for what the person wants, is interested in.....
- The assessment informs the service plan



# Assessment and Planning Domains

## Areas of Focus for Assessment and Planning

- Housing and homelessness history and barriers to stability
- Income and financial literacy, education/training and employment
- Life skills
- Family, friends, and other supports
- Psychiatric and substance use issues
- Health and medical issues



Assessment looks at history, current, strengths, barriers, motivation and GOALS

Service plans reflect the person's goals and connects housing success to those goals

# Understand Housing and Homeless History

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## Housing History –

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



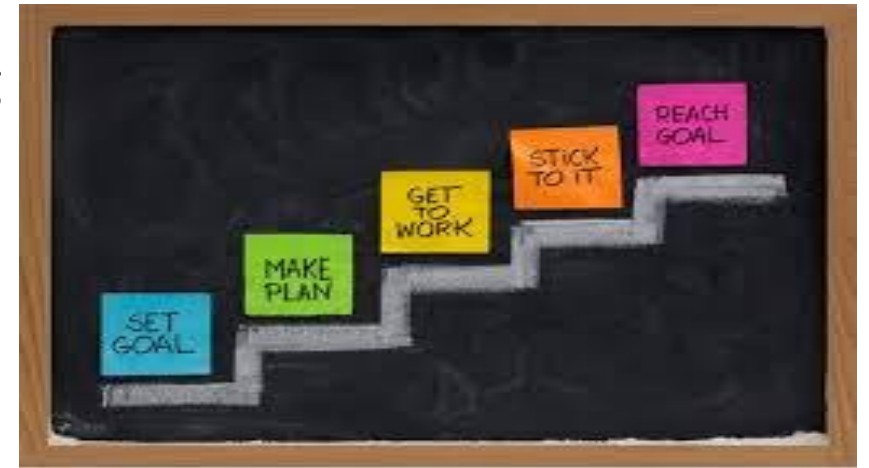
## Homelessness History -

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

# Goal-Setting and Service Planning

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- The Service Plan guides and provides structure for the work.
  - If you are working on setting goals and developing a Service Plan with a person, they should be **enrolled in your program**
- Goals are set in partnership with the participant and focused on what matters to them.
  - Things people “can feel”
  - “So that” principle. I want x so that y happens
- Makes progress possible by breaking out small steps to achieve each goal



# Housing Focused Service Plan

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- The Plan includes both short and long-term goals
  - Try to limit goals to no more than 3.
  - Focus – income, housing, supports
- Use the Plan to build motivation for housing - raise confidence, competence & importance
  - Success on service plan goals builds confidence for more changes
- Include tasks for worker and participant



# Housing Focused Service Plan - 2



- Include connections to high quality, sustainable resources, services & supports
- Update plan frequently
  - Quarterly is standard but more often if needed
  - Requires on-going assessment - Informed by discussions with client, team, informal supports & community resources.
- There is no Service Plan in the HMIS
  - Use paper templates or your own and upload into the HMIS
- Review Sample Plan
  - Completed Sample

# Assessment and Service Planning Webinar

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Presentation Slides: [PATH Assessment and Planning - PDF](#)

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



# Discussions: Exploring Goals Discussion (Groups of 3)

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- Person 1: Share example of a client goal or give example of a goal of your own (simple, not too personal)
- Person 2: Staff that has the “so that” conversation to find out:
  - Reasons behind the goal
  - “So that” what?
- Person 3: Observer gives feedback to the others & reports back on conversation

# Partnerships and Linkages - Examples

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- Housing: CAN, landlords, vital documents, emergency assistance,
- Financial: benefits & employment income, credit repair, financial literacy
- Health: regular physical and dental check up, specialty care
- Mental Health/Substance use: psychiatry, therapy, medication management, detox, rehab, peer support, mobile crisis
- Social connection: family, friends, faith/spirituality, group membership, domestic violence services
- Life skills: home care, cooking, shopping, transportation, recreation
- Legal: civil, criminal, immigration legal services
- Education: GED, training opportunities, ESL, trade school, college

# Coordinating with Partners & Making Successful Linkages

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Be knowledgeable

- Know full range of resources in your community
- Ask users for feedback
- Know what they provide, eligibility, application process

Introduce yourself and your service

- Identify how you can help partner meet their goals
- Explain your role and what they can expect from you
- Gather and share history (with consent)

Accompany to assist with engagement

- Maintain regular contact to see how things are going
- Keep your promises

# Income Assistance - Benefits & Employment

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- 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 steps into manageable pieces.
- Explore formal and informal work (e.g., sweeping up, lawn mowing, day labor).



# Income and Benefit Sources

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## 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 TA (SOAR TA ended in 2025)
  - CT DMHAS has a website with contacts and general info
    - [CT SOAR](#)
  - PRA maintaining a website with resources, newsletter etc
    - [PRA SOAR](#)
- [American Job Centers](#)
- [DMHAS Supported Employment](#)



# Accessing a Temporary Place to Stay



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**What are the options?**

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Shelter/Hotel/Motel?

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Doubling up with friends/family?

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**What are the responsibilities?**

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**How does it connect to what the person 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

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[Housing Preferences Worksheet - DOC](#)

# Webinar: Helping Clients to Understand Housing Options

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Presentation slides:

[Understanding Housing Options – PDF](#)

Webinar recording:

[https://youtu.be/NI\\_8EzpHEv4](https://youtu.be/NI_8EzpHEv4)



# The Transition to Housing

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- Opportunity for change and a new start
- Both loss and gain
- Can increase symptoms
- Involves lots of unknowns
- Unknowns/uncertainty can create anxiety
- Requires a new daily schedule and role(s)
- Can triggers fears of failure



# Discussions

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What challenges have you seen clients face when they transition to housing?

- What supports have helped with the transition?



# Support During Housing Application & Move-In Process

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- 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.
  - Offer support post move-in for 90 days post lease date – may keep enrollments open
  - Do warm handoffs with new providers



# Warm Hand-offs

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- Leverage outreach workers' deep ties to transfer engagement to the new worker
  - Accompany clients to appointments with new service providers whenever possible
  - Clarify roles with housing case manager or other ongoing support staff
    - Decide who will do what – e.g., PSH will lead on communication with landlord, Outreach can support with connections to new resources
- Provide follow-up support on a gradually declining basis post move in to housing
  - *Standard: monthly attempts to visit or contact clients after move-in to assess on-going service needs and connect clients to appropriate services for at least 3 months after move-in*



# Closing Comments

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# Closing

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- Housing focused case management:
  - seeks to understand clients housing preferences
  - eliminate barriers to housing access and
  - connect to the supports needed to get and keep housing
- In housing-focused case management, we
  - support people in setting a housing goal and
  - working toward it using the Service Planning Process
- We meet clients where they are and help them get to where they want to be
- The transition can be tough so extra support before and after the move into housing is critical.





# Additional Resources

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# Best Practices in Street Outreach – Part 1

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[Slides](#)

[Recording](#)



# Upcoming Outreach Webinars:

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- Best Practices in Street Outreach – Part 3
  - March 31 from 1:30 – 3:30 pm
- Safety on Outreach – Date TBD



# Communities of Practice: Schedule

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All meetings will be from 10-11 AM

- Thursday 4/2/26
- Thursday 6/4/26

**Join Zoom:**

<https://us02web.zoom.us/j/89419988419?pwd=5bzO1dsm5saZCmxXOBfnLcJb2Yd3iK.1>

Meeting ID: 894 1998 8419

Passcode: 917908

Phone: 646-876-9923



# Quarterly Outreach Meetings

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Next Meeting: TOMORROW

- 3/18 at 1pm

**Join on your computer or mobile app**

[Join the meeting now](#)

Meeting ID: 292 226 753 998 75

Passcode: KM2s6G66

**Dial in by phone**

[+1 860-840-2075,,378925443#](#) United States, Hartford

[Find a local number](#)

Phone conference ID: 378 925 443#

# Street Outreach Training Inventory

Web-based training available on topics including:

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- Best Practices and Engagement Strategies
- Homeless Response System Overview
- Housing Options
- Housing Assessment & Planning
- Mental Health
- Crisis Intervention & De-escalation
- Harm Reduction
- Encampments
- Trauma-Informed Outreach
- Self-Care, Vicarious Trauma & Staff Resiliency
- Working with Special Populations (Youth, Older Adults, LGBTQIA, DV)
- Racial Trauma & Equity
- Disaster Response Planning



# Other Resources

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- [CT Homelessness Response System Acronyms](#)
- [Core Elements of Effective Street Outreach to People Experiencing Homelessness](#) (United States Interagency Council on Homelessness)
- [19 Strategies for Communities to Address Encampments Humanely and Effectively](#) (United States Interagency Council on Homelessness)
- [National Outreach Guidelines for Underserved Populations](#) (Health Outreach Partners)
- [Within Reach: Perspectives of Hard-to-Reach Consumers Experiencing Homelessness](#) (National Health Care for the Homeless Council)



# Quarterly Outreach Meetings

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Next Meeting: 3/19 at 1pm

**Join on your computer or mobile app**

[Click here to join the meeting](#)

Passcode: YRSRpB

**Or call in (audio only)**

[+1 860-840-2075](#)

Phone Conference ID: 636  
766997#

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# Thank you! See you on March 31<sup>st</sup>!

Please turn on your cameras to say good-bye

