Connecticut Statewide Street Outreach Guidelines

CT Department of Mental Health and Addiction Services
& CT Department of Housing

Spring 2022

Purpose

This document outlines guidelines for Homeless Street Outreach projects in the State of Connecticut. The guidelines align Street Outreach efforts across the state to support persons experiencing unsheltered homelessness in achieving permanent housing. Alignment with the guidelines is recommended for all programs funded by either the State of Connecticut's Department of Mental Health and Addiction Services (DMHAS) or the State of Connecticut's Department of Housing (DOH).

These guidelines were developed by Housing Innovations on behalf of DMHAS and DOH and represent the Departments' collective stance on the vision, values, goals, outcomes, and practices of Street Outreach projects operating in the state of Connecticut.

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How to Use this Document

The State of Connecticut's Department of Mental Health and Addiction Services (DMHAS) and Department of Housing (DOH) are committed to establishing and maintaining an effective and comprehensive statewide Street Outreach effort to support persons experiencing homelessness in achieving permanent, sustainable housing. These user-friendly guidelines combine compliance-oriented recommendations and essential practices for an effective street outreach program. Together, these serve as statewide guidelines for operating a Street Outreach (SO) project. For outreach staff, these guidelines and the appendices offer a concrete manual of effective street outreach practice.

The guidelines are grounded by a singular vision and values that establish a practice ethos, as well as goals and outcomes by which funders, agencies and projects can gauge progress toward achieving the vision. The document then articulates four sections of standards that outline funders' expectations for agencies, projects, supervisors and frontline staff:

- If you're a frontline street outreach worker, read **Section 1.**
- If you're a street outreach supervisor, read **Section 2.**
- If you're in charge of administering a street outreach project, read **Section 3.**
- If you are an agency administrator, read **Section 4.**

Appendices offer resources for staff who are fulfilling one or more of the roles described in the guidelines. These resources are designed to support staff working within Street Outreach projects with more granular "how to" information to reduce decision fatigue, stress, and burnout, while executing roles more effectively and efficiently. Project administrators, frontline staff, and supervisory staff will find concrete checklists and guides to support the different functions of each role.

PATH funded Street Outreach projects should regularly reference the PATH monitoring guide. Other projects may also find this guide helpful.

Values

- We believe in Housing First. Everyone deserves safe and stable housing.
- We act with urgency. No one is homeless one day longer than necessary.
- We respect clients' perspectives, motivations, choices and property.
- We build trusted relationships with clients and partners as the foundation of our work.
- We minimize risk and reduce harm wherever possible with clients and ourselves.
- We create equitable access to housing for underserved people.
- We are transparent with clients and partners about what we can offer.
- We are persistent but kind with all clients.
- We are allies in our clients' journeys toward housing.
- Our work is part of a network of committed service providers; we rely on each other to do what we each do best.
- We practice and support a culture of self-care.
- We meet people where they are and help develop a vision of where they want to be.
- We are flexible and creative problem-solvers.
- We are committed to data and documentation, and we use them to collaborate and continuously improve services.
- We are rigorous outreach planners; it is the backbone of all our work.

Vision, Goals & Outcomes

Vision.

The primary goal of Street Outreach is to support people experiencing unsheltered homelessness in achieving some form of permanent, sustainable housing.* Teams may use techniques and resources to build trusted relationships and relieve discomfort and risks of living unsheltered, but these efforts are made with permanent housing as the end goal, rather than simply seeking to alleviate the burdens of living on the streets.

Goals.

Street Outreach projects in the State of Connecticut focus on achieving goals that support this vision, including:

1. Quickly connecting people experiencing unsheltered homelessness to safe housing, income, and critical health/behavioral healthcare and other supports, using a Housing First approach;
2. Identifying people living in unsheltered locations and helping them to maximize safety and reduce harm;
3. Minimizing service gaps or duplication;
4. Using available resources strategically to end unsheltered homelessness for as many people as possible, prioritizing those who are most vulnerable and/or have been homeless the longest;
5. Preparing and supporting people to meet tenancy obligations associated with housing; and
6. Providing a warm handoff and aftercare (as needed and available) to connect people to supports in the community that will assist with housing stability.

Outcomes.

Street Outreach projects focused on the goals above will produce a number of positive client outcomes, including the following:

- Unsheltered clients, especially those who are most vulnerable, move into housing*.
- Clients do not experience homelessness one day longer than necessary.
- Clients get supports that help them reduce harm of their current living situation AND prepare them to meet tenancy obligations.
- Newly housed clients get support to adjust to their new surroundings.

**Shelter beds can be used to stabilize a client on their way to permanent, sustainable housing, but shelter is not the end goal.*

Outreach Practice Guidelines

Section 1

Outreach Practice Guidelines

DMHAS and DOH funded Outreach projects are monitored on the guidelines in this section. Other outreach teams are encouraged to adopt the guidelines in their operation.

Key Responsibilities of Outreach Workers.

- **Identifying who is living unsheltered within a defined geographic area.** Outreach workers physically canvass, maintain active relationships with key partners within the defined geographic area who interact with people living unsheltered, get "tips" from the public, often via 211, about people who may be living unsheltered, and may adopt schedules for regular visits to high-volume partner locations.
- **Making contact and establishing credibility with people living unsheltered.** Outreach workers forge primary relationships with people living unsheltered, earning their trust through consistent and reliable interactions where workers can demonstrate kindness and helpfulness.
- **Collecting and entering data into the CT Homeless Management Information System** (CT HMIS). Outreach workers use CT HMIS and associated databases every day to record information about clients they have been in contact with, services that have been provided, progress notes, and other information that needs to be documented for current and future use in working with the client.

Note: *Getting a client's information into a single system means that the client doesn't have to repeat the same information multiple times. It also reduces the information gathering burden that staff within the homeless service system collectively bear. Further, this information is the only way that projects can consistently and accurately report progress toward the outcomes. Entering complete, accurate and timely information is the most important way to make sure the project gets credit for the work you're doing.*

- **Assessing client needs and developing housing and service plans.** Staff begin assessing client needs early on and within 30 days after enrollment, staff have documented in writing a client needs assessment, as well as a service plan to meet those needs.

- **Providing housing-focused case management.** Street Outreach projects are most successful at achieving positive client housing outcomes when they operate with adequate client to staff ratios. Much of an outreach worker's time may be spent providing housing-focused case management. Staff are expected to stay involved with enrolled clients even if they utilize stabilization beds (shelter) while enrolled, until they are housed.

Note: *Focus on quality over quantity. The level of intensity to be successful limits the number of clients a case manager can serve successfully. For instance, vulnerable clients may need hands-on assistance to access services and supports. Someone may need some coaching on meeting with SSI, a potential landlord or even gaining access to needed psychiatric and or medical services.*

- **Coordinating with partners to move clients into housing.** Outreach workers regularly communicate with partners to make sure that their clients are getting access to housing opportunities and other essential services.

Some examples include:

A non-PATH funded outreach worker makes contact with someone living unsheltered and preliminarily determines that the person is eligible for PATH services. The outreach worker calls or emails their PATH funded counterpart and makes the effort to personally introduce them to the contact.

An outreach worker attends a regular meeting to match clients to available housing units, using the meeting to make sure all of the client's information, needs and housing preferences are available to decision-makers.

An outreach worker receives referrals via phone or email from 211 operators for someone living unsheltered. The worker gets location details from the 211 operator and makes every attempt to find the person in the next 24 hours.

Outreach workers within a specified geography attend a regular alignment meeting to balance out caseloads, hold each other accountable for agreed-upon commitments, and work out new or modified staff: client pairings when relationships between staff and a particular client stall out.

Develop a Relationship with Clients from Day One.

- Begin developing relationships with clients from the first time they encounter someone living unsheltered and continue with that relationship until after the client has moved into housing or been engaged by a new case manager.
- Begin by building trust, gradually engaging, and working toward acceptance of services and housing offers.
- Talk about opportunities, resources, service possibilities, your role and the team(s) you work with, successes others have had as a result of working with you or outreach colleagues, etc. Keep in mind that your outreach team may or may not be the primary team working with this individual, so take care to include other outreach teams in your description of who can help.
- Keep it simple so you don't overwhelm with information.
- Don't lose sight of the primary goal: getting someone to talk to you and tell you some of their story.
- The length of this process varies widely, given the individual circumstances of people living unsheltered.
- Your relationship does not end until after the client moves into permanent housing. Shelter is a step along the path, not the end goal.

On Day One, *your goal is to create a "why" for the person to engage with you. Identify yourself and your organization and get the person to talk to you.*

Ask open-ended questions and get to know the person without pushing any agenda. Actively listen to what the person is telling you they need and want. Figure out which basic needs you can help the person meet and what you can do to relieve discomfort. Ask what they want or need. Work on small tasks so that people get something out of the interaction — this could be a blanket, coffee, or information. Make sure you have hygiene packets and other supplies whenever you go out in the field. Check HMIS as soon as you can, and read all client case notes available to you.

Q: How do I know if I was successful at Day One engagement?

A: The individual wants to speak with me again.

Keep up momentum with these tips:

Engage again within 48 hours

If you are handing off further engagement with the client, consider bringing the outreach worker who will continue engagements with you on your follow-up visit. Follow through on the commitments you made to the individual during your first contact.

If you have just received a referral and have not yet met the client, try to accompany the outreach worker who first engaged the client when they go back a second time.

Regardless of whether you can go with the other outreach worker, make every attempt to engage your new client within 24 hours of receiving their name/information and location.

When meeting someone new, some behaviors make you feel comfortable and more receptive to talking and others make you feel less receptive:

More receptive...

- Is open to your opinions
- Listens to you
- Makes eye contact
- Responds to you
- Focuses on your needs

Less receptive...

- Pushes a point of view
- Gives one opinion after another
- Displays body language of disinterest
- Answers phone during a meeting
- Has own agenda in forefront

First Contact Practices:
Closing the Loop During & After First Contact

Before Leaving the Engagement:

- ☐ Did I offer something that would reduce the person's risk, harm or discomfort?
- ☐ Did I do a 360 scan for **emergency needs** (acute physical or mental health problems, e.g., imminent risk of suicide, homicide or other harm)?

> ***Note:*** *If you believe there is imminent risk to the person or others,* ***call 911****. If they are hospitalized, check on them and continue the relationship.*

- ☐ Did I get the person to talk to me?
- ☐ Did I ask about whether they need an ID, Social Security Number or SSN card?
- ☐ Did I ask the person about income?
- ☐ Did I ask about military service?
- ☐ Did I reinforce a strength or positive behavior the person demonstrated? What about the progress we made today? e.g. "We completed a release so we can get you healthcare." or "We found a place you can do laundry."
- ☐ Did I talk to this person about their plan to end their homelessness and what help they need?
  - ☐ If they indicated they have family or friends who could be a source of safe housing, did I ask if they need help to get in contact with them?
- ☐ Did I commit to coming back and give the person a general sense of when that will be?
- ☐ Did I ask "If I can't find you here, where are the places I can find you?" and "Is there a way to contact you if I can't find you?"
- ☐ Did I look for signs that this person has mental illness or substance use disorder?
  - ➡ See Presumptive PATH Eligibility Scan for concrete indicators

Continued...

Within 24 Hours of the Engagement:

- ☐ Record **the person and their location in HMIS or other database in use by the CAN?** (for all contacts)

> ***Note:*** *Enter something into HMIS, even if it's "red baseball cap under bridge" and nothing else.*
> *YOU DO NOT NEED TO COLLECT A FULL CLIENT RECORD TO ENTER INTO HMIS.*

- ☐ Did I follow the standard for recording client location?

> ***View guidance on recording client location here:***
> *https://docs.google.com/document/d/1U6c1YwFp0p15wIgHqr6jEGmZP7__eWW_HR4dTENaIJw/edit#heading=h.lsc19oux0rkx*

- ☐ Write down the commitments I made to this person so I won't forget, e.g. when I will come back, what I will bring or do for this person?
- ☐ Record in case notes where I can find the person and how to contact them if I can't find them?
- ☐ Record in case notes any family or friends who could be a source of safe housing. Have I followed up already? If not, what's my plan to follow up in the next 24 hours?
- ☐ Does this person appear to meet the criteria for PATH, i.e. behaviors that indicate mental illness and/or substance use disorder?
  - ☐ *If I do not receive PATH funding, have I noted likelihood of PATH eligibility in case notes and flagged this person for either immediate referral to PATH or discussion at the CAN outreach meeting?*
  - ☐ *If I do receive PATH funding, have I begun planning for pre-enrollment activities that will help this person move toward housing more quickly?*

See CT's Guidance on Documenting Serious Mental Illness for DMHAS PATH Projects at ***https://www.ctbos.org/wp-content/uploads/2022/01/Documenting-SMI-PATH-v3-docx.pdf***

Presumptive PATH Eligibility Scan

I. Homeless Status:

- ☐ Literally homeless.
- ☐ Living in a place not meant for human habitation (unsheltered).

II. Mental Illness:

- ☐ Known mental illness.
  - *If there is a history available, rely on that. If not, ask the person if anyone has ever talked to them about psychiatric symptoms, if they've ever been in a psychiatric hospital, or ever been asked to take medication for mental illness.*

- ☐ If no known mental illness, look for behavioral signs of mental illness.
  - *Is the person responding to unseen stimulus: talking on their own, eyes shifting as if they hear something, hearing voices, fixed beliefs that seem not based in fact but are set (I am being followed, the government is listening to everything I say, I can't go into a shelter because "they" are there, etc.)*
  - *Affect that doesn't fit the circumstance — flat, laughing, seem agitated, fearful.*
  - *Thinking that may be confused, grandiose (I am very rich and own most of the town, I am a mind reader and know what you are thinking, etc.)*
  - *Have trouble carrying a conversation, unable to make eye contact.*
  - *How they maintain themselves physically — is their stuff disorganized and/or dirty?*

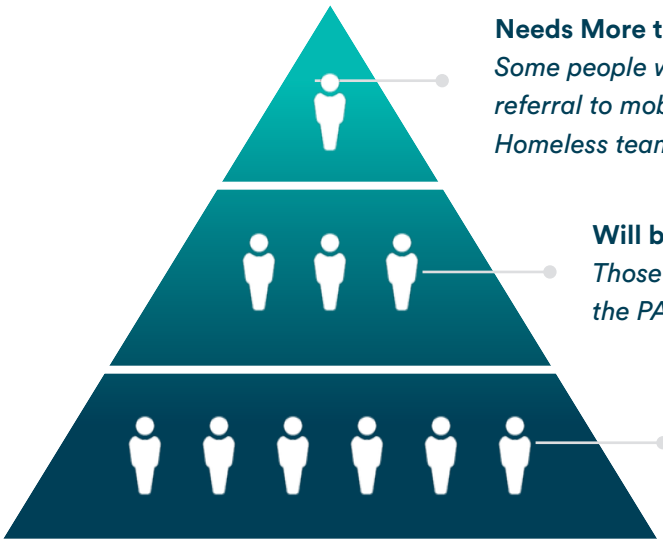
- ☐ Any observed behaviors (above) seem to interfere with getting basic needs met.

III. Substance Use Disorder:

- ☐ Known substance use disorder.
  - *If there is a history available, rely on that. If not, ask the person about current use and what their usage does for them (positives and negatives).*

- ☐ If no known substance abuse disorder, look for behavioral signs of substance abuse.
  - *Symptoms of intoxication and/or withdrawal.*
  - *Keeps company with persons with known drug / alcohol disorders or has drug or alcohol paraphernalia (syringes, glass pipes, empty liquor bottles) around.*
  - *Talks about drugs and alcohol regularly.*
  - *Acts differently at different times: clearer in the morning or gets agitated in the afternoon.*
  - *Speech and thinking patterns seem off.*
  - *Unkempt.*
  - *Always out of money.*
- ☐ Any observed symptoms (above) seem to interfere with getting basic needs met.

Outreach Service Options for People Living Unsheltered



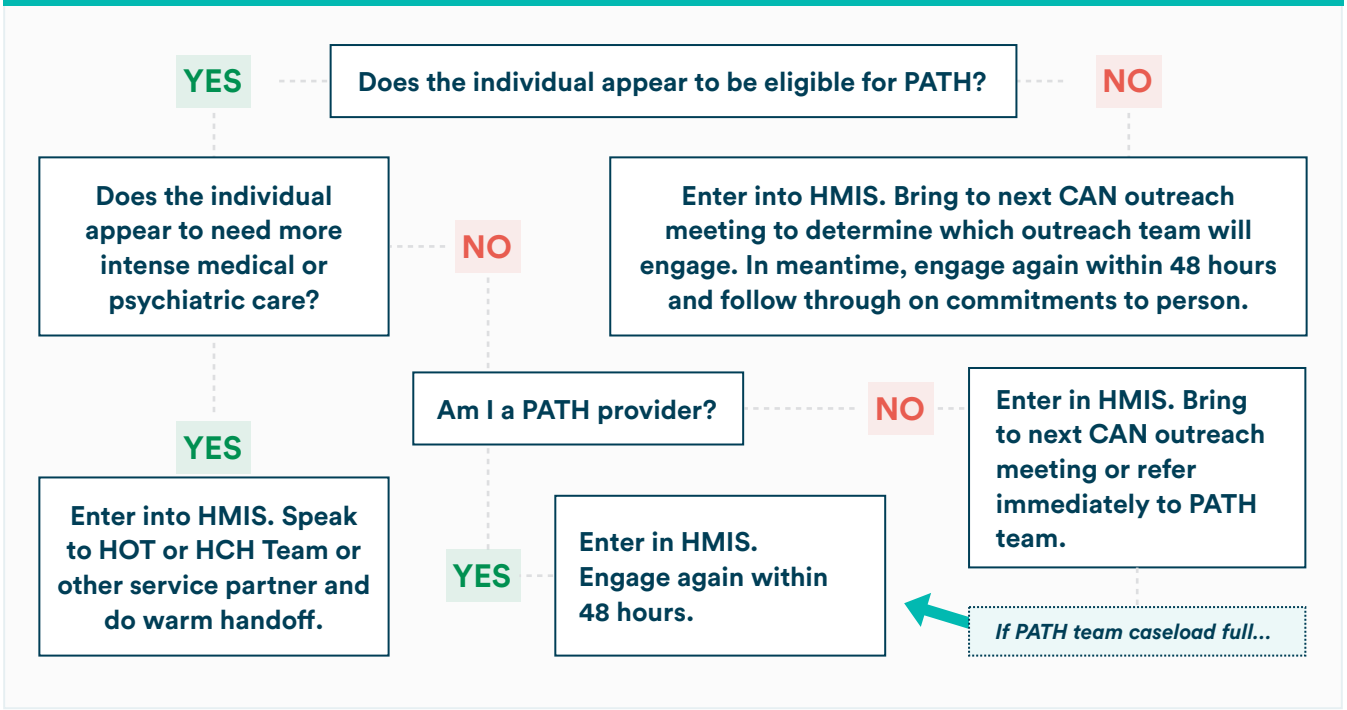
Needs More than PATH.
Some people with more significant impairments will need referral to mobile crisis intervention or Healthcare for the Homeless teams for more intensive medical or psychiatric care.

Will be enrolled in PATH.
Those who appear eligible for PATH enrollment are referred to the PATH funded outreach team.

Not eligible for PATH.
Most will not be eligible for PATH enrollment. DOH and DMHAS outreach teams will have to determine how to assign responsibility for these clients between the teams.

Next steps for each individual will depend on presumptive determinations of PATH eligibility and an assessment of whether the individual needs more than the outreach teams can offer. Each CAN has an outreach meeting in which representatives from all teams in the CAN make decisions about which team is able and best suited to further engage an individual. Some CANs have VA Outreach services that may be an option if the client has served in the military. Consult the decision tree below to determine the appropriate next steps for a new contact:

USE IMMEDIATELY AFTER FIRST CONTACT



Discharging to shelter is an inappropriate outcome

Respect Client's Rights

Outreach workers must operate in ways that respect each clients' rights to confidentiality, to make grievances, and to decide how and when their personal information is disclosed. Specifically, staff must do the following for all clients:

- Adhere to confidentiality requirements in all discussions with participants, colleagues, and collateral contacts regarding participant information, as well as in handling participant records.
- Obtain and file a signed release of information for disclosures of confidential information
- Inform outreach participants early and often about how they can use the grievance process to grieve eligibility and termination decisions and other issues.
- Outreach workers must operate in ways that respect each clients' rights to confidentiality, to make grievances, and to decide how and when their personal information is disclosed.

Releases of Information *(ROI) are used by all homeless service providers in the State of CT as a way to ensure that clients understand and agree to disclosures of information. ROIs are not only required for all Street Outreach clients; they represent an opportunity for outreach workers to describe to the client that there is a broader system of housing and service partners who can support them to get housing and their other needs met.*

Provide Housing-Focused Case Management

It's the end of Week 2. How do you know if you're on track?

- ☐ *I have gotten my client a State ID if needed.*
- ☐ *I have started benefits applications with or for my client (referring someone to an application is not an appropriate level of support).*
- ☐ *I have a clear sense of what my client's housing plan, goals and preferences are and have gotten specific information on different housing options from my supervisor, CAN staff, and/or colleagues.*
- ☐ *I followed through on commitments to my client and have a plan and timeline to meet with them again.*

Housing focused case management begins early in the process of engaging an individual living unsheltered. Case management time must be spent on activities primarily aimed at quickly connecting unsheltered homeless individuals and families to safe available housing, as well as income, health/behavioral healthcare and other supports, including:

- Screening enrolled clients for public benefits eligibility and assist in applying for benefits, including SSI/SSDI, Medicaid/Medicare, SNAP, TANF, and other non-cash or cash benefits. **Assistance could be helping someone fill out an application or filling it out for them.**

Note: *Referrals alone do not meet this standard.*

- Screening enrolled clients' **SSI status** and connecting them to a **SOAR trained case manager.**

Note: *All frontline staff need training in how to conduct a functional assessment on the impact of someone's disability on daily functioning.*

Pro tips:

- *Get records from anywhere the person has been treated.*
- *Find out if the client ever had SSI. If so, SOAR is unnecessary — update their application to reinstate benefits.*
- *If you observe an obvious disability, physically go with the person to the SSI office to apply for presumptive SSI. This includes visible physical disabilities, clear signs of mental illness, etc. Presumptive SSI can be obtained in two weeks and lasts six months while official SSI is obtained, without the threat of paying those six months back.*

- Screening for a history of military services and connecting them to Veterans Affairs (VA) Outreach and services.
- Accompanying enrolled clients to their initial appointments for other services, benefits, CAN assessments, and housing appointments whenever possible, including offering transportation, assisting with applications and interviews, providing client documentation, and acting as an advocate for your client.
- On an "as needed" basis, assisting clients to access a stabilization bed temporarily on the path toward permanent housing.
- Using **"warm hand-offs"** to help clients establish a relationship with staff providing on-going services.

Note: *Well-handled referrals are essential to helping clients successfully access homeless services and resources.* ***Referral Pro Tips:***

- *Referrals should be made as a "warm hand-off," in which outreach workers personally introduce clients to their new providers, benefits staff, or outside community agencies/providers.*
- *Outreach workers should communicate with colleagues about referrals in person, on the phone, via HMIS, or other direct communication options. Email should be a method of last resort.*
- *For referrals that aren't straightforward and may need more people to weigh in, outreach workers may need to conduct case conferences with multidisciplinary teams to coordinate referrals.*
- *Remember that clients also have to exercise personal initiative, upholding the equal, collaborative relationship between staff and clients.*

Maintain a Client Centered Approach

- Work persistently, e.g., offering services multiple times in different ways, talking over coffee, etc., to assist clients in locating safe temporary accommodations and permanent housing that can accommodate their entire family, including any pets.
- Assist clients with a Housing First approach, making sure they can access permanent housing without unnecessary prerequisites such as abstinence, treatment, service participation requirements, or other determinants of "housing readiness".
- Try to understand clients' perspectives, including any reasons why they are not using shelter and/or other services, and accept choices as a matter of fact without judgment. Know that people bring different experiences and priorities to this process —

Continued...

the outreach worker's role is to listen and negotiate with clients on how best to meet their needs.

- Build trust by helping clients solve problems that are most important to them, which could be very concrete like safety, medical care, transportation, protection from the weather, access to food, water, clothing, sunscreen and toiletries, and companionship.
- Offer flexibility in how, where, and when services are provided, e.g. if someone wants shelter immediately, help them get into shelter and continue working with them.
- Provide case advocacy on behalf of clients to make sure they receive needed services.
- Help clients understand risks and reduce harm caused to themselves and others by risky behavior.
- Notify supervisor or colleagues of where you will be, for how long and when you will check in.
- Complete all required trainings, e.g. de-escalation, harm reduction, and other safety skills.
- Follow all safety protocols established by the project.
- Follow incident reporting, management, and follow-up protocols.
- Clients may not make progress on your timeline. Keep helping and understand that there are limits to what you as an individual can do. Give grace to the client and yourself.

Maximize Safety and Reduce Harm for Outreach Workers and Clients

- Act in a trustworthy and transparent way, following through on commitments and being honest about what you can and cannot do.
- Recognize signs and symptoms of trauma, avoiding known triggers for clients, and responding to reactions effectively, including being predictable and reliable regardless of client response.
- Learn clients' histories of risky or dangerous behavior. Always check HMIS case notes.
- Intervene as necessary when someone presents an imminent risk of danger to self or others.

Conduct Needs Assessment and Create Housing Plans

- Generally by the second contact, outreach workers need to begin asking about the individual's housing plan, goals, and preferences.
- Active listening is beneficial, checking to make sure your understanding is right by reflecting back to the client what you think you heard.
- If you're able, talk through the positives and negatives of different housing options, starting from what the client has in their mind.
- Avoid giving "reality checks" to clients, e.g. "You'll never be able to afford that."
- Start to bring the client's longer-term goals into focus by describing different paths to reach those goals.
- If the client is behaving in ways or engaging in activities that aren't in service of those longer-term goals, ask how important it is to keep doing those activities or behaviors, and negotiate with them on how to minimize the impact on their longer-term goals. This part of the engagement is about getting people to think through other ways they might achieve short-term gains or at least get them thinking about how it impacts other things they need or want. Do not use guilt, blame or direct confrontation to prompt behavior **changes**.

Being Proactive Pays Off: *Over the next week, assess for which needs are most time-consuming or require the longest lead time, and get started on these first. Outreach workers need to proactively tackle the tasks that will be critical to obtaining and sustaining housing. Waiting to begin these tasks can have major negative impacts on both obtaining and sustaining housing later in the rehousing process, especially income. Outreach workers can roughly follow the order of priority below, making tweaks as the situation demands:*

- *State ID*
- *SSI application, noting that most people do not require a full SOAR application. Only those with complicated SSI claims such as severe psychosis, SUDs, or other complex disabilities will need SOAR. For everyone else, the usual process is sufficient if started early enough. Get some tips from the SOAR team about how you can support a non-SOAR application*
- *SSDI application, including verification of disability, only if work history seems to indicate that SSDI is a possibility (see https://www.ncoa.org/article/ssi-vs-ssdi-what-are-these-benefits-how-they-differ)*

Continued...

- *Employment*
- *SNAP/Food Stamps application*
- *Social Security Number and/or SSN Card application*
- *Medicaid/Medicare application*
- *Connecting/reconnecting with natural support network (family, friends) who may be able to support the individual*

Support Clients Through the Housing Application and Move-in Process

- Participate in CAN Case Conferencing and Housing Matching meetings as necessary to ensure all eligible persons have an opportunity for referrals to housing.
- Make at least monthly attempts to visit or contact clients after move-in to assess on-going service needs and connect clients to appropriate services as necessary for at least three months after move-in.
- Prepare clients for success by thinking through contingencies in advance of housing and mitigating risks to housing stability. Consider the impact of how a client structures their days, roles they play in their social networks, habits and patterns of behavior that could lead to housing solutions like:
  - *Housing multiple unsheltered persons who make up a social network either on the same lease or with separate leases, in nearby units, within the same timeframe, and other ideas to successfully stabilize a group of people who are close.*
  - *Anticipating hoarding patterns by purchasing clear storage bins, negotiating limits on how much stuff is allowable in the unit, visiting more frequently to assess the amount of stuff and assisting with removal of excess stuff.*
  - *Anticipating the need to help the client maintain their relationship with the outreach staff, as well as form trusting relationships with other service provider staff by accompanying them to appointments and staying temporarily engaged with clients after they are housed to increase feelings of stability, companionship and trust.*

Plan Ahead for Successful Transitions

- Incorporate the expectation of an eventual transition to another provider early in the engagement process. Taking this early step helps to ease transitions later in the process.
- Actively involve the client in the referral process and attend to the client's emotional concerns about the transition.
- Inform the staff of the linkage site about the client's needs and characteristics and provide them with technical assistance and emotional support for their concerns.
- Provide follow-up support on a gradually declining basis to both new staff and the client to prevent abandonment issues.

Consistent Practice:
Doing Your Homework Between Contacts

Before Leaving the Engagement:

- ☐ Did I offer something that would reduce the person's risk, harm or discomfort?
- ☐ Did I revisit their plan to end their homelessness and what help they need?
  - ☐ *If circumstances have changed with family or friends who could be a source of safe housing, did I ask if they need help to get in contact with them?*
- ☐ Did I commit to coming back and give the person a general sense of when that will be?
- ☐ Did I revisit benefits and income with the client and get their consent and availability to set up necessary appointments?

Within 72 Hours of the Engagement:

- ☐ Write down the commitments I made to this person so I won't forget, e.g. when I will come back, what I will bring or do for this person.
- ☐ Record in case notes any family or friends who could be a source of safe housing. Have I followed up already? If not, what's my plan to follow up in the next 24 hours?
- ☐ Using a basic sense of the client's housing plan, goals, and wishes, work with supervisor to determine which housing options seem like they might work for the client.
  Get specifics of eligibility, waitlists, and other relevant information from your supervisor to prepare for your next discussion with the client.
- ☐ Set up appointments for your client and make sure your schedule allows you to accompany them.
- ☐ Fill out benefits applications as needed.
- ☐ Enter additional client information into HMIS and update case notes.

Checklist[1]:
Maintaining Safety for Clients and Staff

Frontline staff must complete required safety trainings before conducting outreach

General Ways To Create Safe Spaces:

- ☐ Listen
- ☐ Be reliable and supportive
- ☐ Explain your role
- ☐ Work together on something
- ☐ Provide some comfort and/or relief
- ☐ Provide support for whatever feelings someone is having

Before Going Out in the Field:

- ☐ Am I following the coordinated outreach plan? *(Ok to not follow only if responding to an emergency)*
- ☐ Is my cell phone charged?
- ☐ Do I have business/contact cards and my ID?
- ☐ Did I tell my supervisor or another staff person where I'll be and when?
- ☐ What is my plan for checking in? *Agree on how often to text your supervisor or colleague to verify that you are ok. Consider setting an alarm on your phone to remind you.*
- ☐ Did I remind [agency/partner] that I will be canvassing in this area today?
- ☐ Did I remove any valuables from my pockets or bag?
- ☐ Am I carrying incentives? Can I put them somewhere safe other than on my person?
- ☐ Am I wearing comfortable clothing and shoes I can move easily and walk/jog in?
- ☐ Do I remember my agency's contingency plan for worst-case scenarios or dangerous situations? *If not, review.*
- ☐ Know your backup. If it is a partner, know where they will be. If it is the police or ambulance, how long will it take to get there. If it is a crisis team, how long will it take. Plan any interventions accordingly.

*1 Adapted from one originally developed by outreach workers in Skid Row, Los Angeles, found in NCHCH's **Workplace Violence: Prevention & Intervention: Guidelines for Homeless Service Providers (2011)***

While You Are in the Field:

- ☐ Introduce yourself and inform people of what you are doing and why. It is best if you are introduced by someone who knows the person — a librarian, soup kitchen worker, another homeless person you know.
- ☐ If working with a partner, always present yourselves as a team.
- ☐ If someone does not agree with what you are doing, avoid engaging in argument and try to put physical distance between you and them.
- ☐ Identify an emergency exit route each time you enter a new situation. If none, do not enter the area.
- ☐ Never enter clients' cars, homes, or any enclosed areas that don't have a clear emergency exit route.
- ☐ Never approach those who are giving "signs" that they do not want to be bothered.
- ☐ If you see that sale of sex or drugs for money is in progress or being set up, leave the area immediately without drawing attention to yourself or others.
- ☐ If you know someone is holding illicit drugs, wrap up the interaction as quickly as possible. Do not accept or hold any type of controlled substance.
- ☐ Stick to your plan to text your supervisor or colleague at the agreed-upon time. Inform them of any unusual developments.
- ☐ In an emergency, call 911. Do not separate from partner unless staying would increase your danger.
- ☐ Do not accept gifts or food or buy any merchandise from clients; however, you might bring a coffee or a snack so that you can have it together.
- ☐ Do not give or lend money to clients — clients may avoid you if they cannot repay it. Money becomes the focus and does not help the client move toward longer-term goals.
- ☐ Maintain confidentiality of all clients you meet.
- ☐ Tell clients approximately when you will be back and how to reach you. Give clients your card. Ask them where you can contact them if they are not in the same spot.

De-Escalation Methods

To learn more, check out these resources:

Crisis Prevention Institute | www.crisisprevention.com

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

The Center for Nonviolent Communication (website) | www.cnvc.org

QBS, Inc. | Quality Behavioral Solutions (website) | www.qbscompanies.org

Behaviors Indicating Agitation and Potential Physical Aggression:

- Change in pitch of voice (either screaming or very soft) or quickening rate of speech.
- Verbal threats, abuse, profanity or argumentative behavior.
- Increasing signs of tension, including clenched jaw or fist, rigid posture, fixed or tense facial expression, frowning, tears, eyes widening, shaking or trembling.
- Intense eye contact or avoidance of eye contact.
- Increased psychomotor restlessness (i.e., a feeling of restlessness associated with increased motor activity such as pacing, wringing hands, picking at skin, twisting hair, etc. This may occur as a manifestation of nervous system drug toxicity or other conditions); or
- Catastrophic or over-reaction to a minor stress; escalating behaviors or explosive loss of control.

The goal is always to protect potential victims, yourself, and others, de-escalate the situation, and help the individual regain control. Behavioral strategies to reduce agitation:

- ☐ Speak in a soft, quiet, even-toned voice.
- ☐ Exhibit a calm manner.
- ☐ Repeatedly call the person by name (if known).
- ☐ Maintain appropriate eye contact.
- ☐ Do not argue, point finger, fold arms, or take a “John Wayne” stance. Standing sideways is best.
- ☐ Calmly ask what the person needs. Allow time and space for a response. The goal is to help the person regain control of their situation.
- ☐ Offer to leave and come back another time.
- ☐ Encourage the person to sit down by sitting down yourself.

Behavioral Strategies To Reduce Potential of Assault:

Note: *Sometimes people are lashing out because they are scared. Acknowledge that the person may not feel safe and ask what would make them feel safer. If a delusion is causing the behavior, do not argue with the delusion (e.g., no one is following you). Focus on what would help them feel safer.*

- ☐ Scan the area for other people, potential weapons and obstacles.
- ☐ Stand sideways and when you change place or position, do so calmly.
- ☐ Do not crowd the person or touch them. Give them space and be sure that the person has a way to exit the situation if they choose.
- ☐ If others are around, ask the person "Is there somewhere we could go to talk?" An audience can feed escalation behaviors.
- ☐ If the person you are seeing is engaged in a conflict with another person, do not get in the middle.
- ☐ Maintain appropriate eye contact; continue calling the person by name.
- ☐ Keep the person talking; use "please".
- ☐ Help the person save face. Make it look more attractive to calm down than to assault.
- ☐ Do not mistake anger for aggression.
- ☐ If someone is paranoid, do not argue or confront. Give the person as much control as possible.
- ☐ If others are with you who can help, use methods of talking "to and through" the individual to let others know your plan.
- ☐ If there is a crowd gathering, try to move others away.
- ☐ Be aware of the usual progression of aggression and have a plan if physical assault occurs.
- ☐ If things are escalating and de-escalation techniques are not working, back off and get help. Pay attention to your instincts.

Check out NHCHC's ***Promoting Safety in Street Outreach***

Supervisory Guidelines

Section 2

Supervisory Guidelines

Projects should have supervisory capacity to ensure their long-term sustainability, decrease staff turnover, and facilitate clients exiting homelessness to permanent housing. Projects are encouraged to establish and maintain a supervisory role to:

- Provide a minimum of one hour of 1:1 supervision with staff every other week; and
- If project has more than one outreach staff, host team meetings every other week and/or regular "huddles" (brief review of the client list and planning for short-term interventions and immediate needs)

Supervisory Guidelines.

Supervisors are responsible for supporting outreach staff in the process of rehousing people experiencing unsheltered homelessness. Supervisors are encouraged to use 1:1 supervision, team meetings, and daily/regular huddles to support staff in the following ways:

- Examine progress on housing targets with outreach staff, troubleshoot barriers, identify fixes and refocus staff on critical tasks through establishment of daily, weekly and monthly priorities (Minimum 1x/month).
- Support staff effectiveness by reinforcing low barrier and assertive engagement skills and how to build participant motivation (as needed).
- Assist outreach staff to strategically plan concrete daily objectives that are aligned with the project's outreach plan (Minimum 2x/month).
- Model collaborative service planning and case reviews with outreach teams (Daily/as needed).
- Revisit the outreach plan regularly, including adjusting canvassing and eligibility documentation strategies as necessary (Minimum 1x/month).
- Reinforce the importance of client documentation and development of meaningful service plans, including helping staff to carve out time for these activities if necessary (Minimum 1x/month).

Continued...

- Practice workload management. Clients may require more time at different points in the process. Ensure that staff have adequate time to carry out the most time-consuming activities such as accompanying people on treatment visits, benefits meetings and landlord interviews (Weekly).
- Ensure that the outreach team is following safety protocols, including establishing an easy way for frontline staff to give advance notice of where/when they will be, practicing check-ins while staff are in the field, pairing staff for less visible visits, and reinforcing safe behaviors in the field (Daily/as needed).
- Provide information on resources that staff need in order to effectively do their jobs. Develop organizational relationships/memoranda of understanding (MOU) with community-based services and supports that staff will regularly be accessing. Advocate for resources for clients (as needed).
- Support staff self-care by recognizing emotional and psychological needs of staff, acknowledging successes, reinforcing boundaries, managing vicarious trauma and burn-out, and prioritizing support to staff involved in critical incidents with clients (as needed).
- Support professional development by connecting staff to training opportunities offered by partner agencies, CoC, or other PATH grantees, and track staff training participation to ensure at least 12 hours of training annually on relevant topics (Minimum 1x/month).
- Maintain up-to-date knowledge on CAN and non-CAN participating housing options and advise frontline staff on eligibility, rules, and availability (as needed).
- Reinforce the importance of timely, accurate, and complete HMIS data entry. Lead staff through data quality review (quarterly) and make sure they receive all available training on HMIS (as needed).

Supervisory Checklist

Semi-Annual Supervisor Self-Check-Ins (Also Use for New Hires):

- ☐ Have staff gone through necessary trainings in the past year?
  - ☐ *Assertive Engagement*
  - ☐ *Motivating for Change*
  - ☐ *Safety Protocols*
  - ☐ *Trauma Informed Practice*
  - ☐ *Housing-Focused Service Plans*
- ☐ Do staff have professional development goals that I can support?
- ☐ Does the staff member have a talent I can call out? Are they good at negotiating with landlords, are they good at SSI, are they good with making a clinical connection, are they a master engager, or other skills that help clients achieve their goals?
- ☐ Have I reviewed staff performance and provided them with concrete and objective feedback, including strengths to continue, growth areas to focus on, and key deficiencies that require immediate remedy?
- ☐ What skills/experience do we need to hire to make the team more effective?

Monthly Check-Ins (Should Be Scheduled Prior to Monthly CAN Outreach Meetings):

- ☐ Did the project reach our internal housing targets for the month? What worked well and what didn't work well? *Discuss barriers and identify solutions. Keep staff focused on critical tasks for housing outcomes.*
- ☐ Did staff across the projects meet their canvassing commitments? If no, why? Can the deficiency be corrected or does it indicate a need to decrease the commitment?
- ☐ What adjustments need to be made to the outreach plan?
- ☐ What adjustments need to be made to caseloads?
- ☐ Are we meeting our commitments to the CAN, including:
  - ☐ *Prompt responses to 211 referrals.*
  - ☐ *Collecting and sharing all eligibility documentation.*
  - ☐ *Collecting and entering CAN required data elements into HMIS.*

Continued...

- ☐ Is the CAN meeting its commitments to outreach projects, including:
  - ☐ *Communication and training on any changes to the CAN assessment process, shelter waitlist protocols, or BNL protocols.*
  - ☐ *Unsheltered clients on the BNL are being referred to permanent housing.*
  - ☐ *Unsheltered clients are moving into housing.*

Weekly/Bi-Weekly Check-Ins (1:1 and Team Meetings):

- ☐ How are each of my staff doing emotionally?
- ☐ Are any staff displaying behaviors or communicating in ways that indicate a need to reinforce boundary setting skills and encourage self-care? What about a need for training in certain areas?
- ☐ Are any staff communicating about clients in ways that indicate a need to reinforce assertive engagement techniques, motivational interviewing, or low barrier principles?
- ☐ Are staff having problems with one or more clients that rise to the level of shifting the client to another person's caseload? Are staff adequately trained and skilled to meet the needs of each of their clients?
- ☐ Are caseloads manageable? Look at acuity, tasks and frequency of contact, e.g. how many clients need a lot of assistance in connecting to resources? Is this manageable?
- ☐ What is the biggest burden on staff this week?
  - ☐ *Is there immediate relief that I or a team member can provide?*
  - ☐ *Is there long-term relief I can seek out through strengthening or establishing a partnership, better coordinating on tasks, or identifying a person or entity who can assist?*
  - ☐ *Is this burden something that I need to bring to our next meeting with the funders to seek an alternative standard?*
- ☐ Are staff allocating appropriate amounts of time to each of their major tasks: canvassing, case management, documentation, data entry, coordinating with CAN and other partners?
- ☐ Canvassing: Who goes where this week and are there any barriers to meeting that commitment?
- ☐ Are staff meeting their milestones with clients?
- ☐ Which client(s) is high priority for our team this week?
- ☐ Are staff setting aside adequate time to enter data into HMIS, including case notes?

Continued...

- ☐ What meetings are staff attending? Any we can remove?
- ☐ Any outstanding 211 referrals? What is the plan for responding to those?

Daily/Regular Check-Ins (Huddles):

- ☐ **Canvassing:** Follow the outreach plan. Who goes where today? If anyone is physically canvassing, reinforce use of safety checklist by using it yourself, e.g., ask where staff will be, is their cell charged, confirm when they will check in and with whom, etc.
- ☐ **Case Management:** Do any staff need information on specific housing options? Commit to doing the legwork on getting that information, e.g. eligibility, rules, availability, etc.
- ☐ **Data Entry:** Check in on HMIS entry and case notes for contacts made in the previous 24 to 72 hours — what's current status and plan for entering into HMIS? Reinforce the need to carve out time for doing needs assessments and developing service plans and entering both into HMIS. Assist staff as needed to shift workloads.
- ☐ **Documentation**: What do staff need help collecting? Are they keeping up with documentation collection?
- ☐ **Coordinating with Partners:** Are there any tasks that require connecting with other partners? If so, reinforce the importance and preferred method of communicating with the appropriate partner(s).

When Critical Incidents Occur:

- Follow safety protocols during and after the incident.
- Help staff members debrief after a critical incident, including documenting the encounter, filing notations in the client's case notes, making recommendations regarding the client's status in the project, identifying what might have been done differently to improve the outcome, and planning for follow up.
- Review staff adherence to safety protocols during the critical incident and ensure that staff receive additional or re-trainings as necessary.
- Provide long-term support to staff involved in the incident. Staff may experience short- or long-term psychological trauma, fear of returning to work, changes in relationships to coworkers and clients, feelings of incompetence, guilt or powerlessness, or fear of criticism by supervisors[2].

2 OSHA. (2004). Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers.

Outreach Project Guidelines

Section 3

Outreach Project Standards

DMHAS and DOH funded Outreach projects are monitored on the guidelines below. Other outreach teams are encouraged to adopt the guidelines in their operations.

Projects are responsible for setting up and operating Street Outreach efforts that serve as the frontline in the process of rehousing people experiencing homelessness, especially those living unsheltered. Projects establish outreach plans; align strategically with other outreach services; partner with CAN and CAN participating agencies; set housing targets and maintain focus on housing goals; and ensure that appropriate client data and documentation is maintained.

Role of Street Outreach Within Coordinated Access Network (CAN) Geographies.

What can CANs do?

CANs are responsible for ensuring clarity, transparency, consistency and accountability for clients and service providers throughout the assessment and referral process, as well as facilitating exits from homelessness to stable housing in the most rapid manner possible. CANs establish policies for prioritization of housing and service resources and ensure efficient and effective access to appropriate interventions.

CT Coordinated Access Networks (**CANs**) provide access to housing resources. DOH and DMHAS funded Street Outreach projects are responsible for linking people living unsheltered to these housing resources. Together with informal outreach partners like soup kitchens, locally funded outreach teams, needle exchanges, police departments, and other municipal departments, Street Outreach projects work to identify and engage people living unsheltered in order to move toward housing. Project responsibilities include:

- Interacting consistently with CAN assessment and referral processes, including:
    - *Reviewing and updating client information, especially location, on the HMIS by-name list to facilitate housing matches for unsheltered clients;*
    - *Participating in case conferencing and housing match communications (meetings, email, calls or other communication) as needed to assist in locating, communicating with, collecting documentation for, and/or offering housing options to clients; and*

- *Collecting and entering data elements into HMIS or other data systems in use by the CAN to facilitate a swift rehousing process.*

Projects are responsible for balancing meeting attendance with other core duties:

- *Canvassing Areas*
- *Engaging Clients*
- *Providing Quality Case Management*
- *Collecting Documentation*
- *Entering Data*

- Providing information to CAN and 211 for the public on how to report concerns regarding an unsheltered person and maintaining a process for prioritizing response to public concerns, as resources allow and circumstances warrant, e.g., frontline staff following up on calls about a person who appears to be experiencing unsheltered homelessness.
- Receiving referrals from the CAN when appropriate, e.g., if someone self reports unsheltered status in a CAN appointment and indicates a lack of interest in shelter, the CAN may contact the street outreach project to engage the person.
- Participating in any coordinated community efforts to assist people living in encampments, including efforts to bring sanitation or other municipal services to encampments.
- Participating in the unsheltered PIT Count.
- Staying up-to-date on CAN's cold weather protocols.

Outreach Planning: Determining Activities To Locate People Living Unsheltered.

***Note:* Outreach projects need to coordinate with other entities within their geographic area to identify people living unsheltered:**

- *Other Service Providers (E.G., Shelters, Day Centers, Soup Kitchens, Health/Mental Health Services, Hospitals, Corrections Facilities, Immigration/Youth/Family/LGBT Services, Etc.)*
- *Community Resources (E.G., Law Enforcement, Transportation Providers, Schools, Libraries, Businesses, Faith-Based Organizations, Etc.)*
- *Homeless and Formerly Homeless People*

Making contact with someone living on the street is the first step in beginning the rehousing process with that person. Within each CAN, the outreach teams working within the geography have to figure out how to plan and execute a comprehensive outreach approach to make sure that all people living unsheltered within the CAN have been identified and engaged. This approach needs to include a subset of the activities below, understanding that within a limited number of hours, outreach teams will determine how to be most effective and efficient at balancing the time spent on each type of activity. Focusing on only one or two types of outreach activities reduces the likelihood that outreach teams will identify all people living unsheltered in the CAN.

* WAYS TO FIND & ENGAGE PEOPLE LIVING UNSHELTERED *	
Physical Canvassing	• *Informed by unsheltered PIT Count* • *Useful for encampments; less useful to locate people living by themselves* • *Efforts can be reduced if outreach team invests in robust remote canvassing*
211 & CAN Referrals	• *Teams receive information from the public about where people are living unsheltered* • *Teams get referrals for CAN clients who refuse shelter*
Remote Canvassing	• *Invest in partnerships with entities who interact with people living unsheltered — these entities serve as "eyes and ears" for outreach teams* • *Outreach team communicates regularly with entities to get information about where people are living unsheltered*
Office Hours	• *Use sparingly* • *Must be a consistent routine to be useful: same day of week/month, same time* • *Set days/times that match when highest volume of people living unsheltered are there* • *Shelters are inappropriate sites to do office hours*

Outreach Planning: Creating and Maintaining the Outreach Plan.

Both DOH and DMHAS funded outreach projects (including sub-recipients) are responsible to act as a cohesive team to establish an outreach plan that covers the entire CAN geography, based on patterns of unsheltered homelessness across the CAN. See the joint checklist for more direction on what to consider when creating and refining the plan.

Note: *Outreach project activities fall into four main activity areas: canvassing/engagement, case management, obtaining documentation/data entry, and coordinating with partners. Each of these areas is addressed in the single outreach plan to ensure that efforts are balanced across these activities.*

Projects are required to:

- Establish a single outreach plan per CAN following a template that encompasses all outreach activities within the CAN, including locally funded outreach teams or other informal outreach partners like feeding programs, police homeless initiatives, etc.
- The outreach plan must detail the following:
  - ***Schedules****, including locations, entities, responsible project/staff, and contact info for each of the "locating" activities (i.e. physical and remote canvassing, office hours), as well as any meetings with CAN, other outreach teams, or other community partners.*

Pro Tip: *Maintain a shared online outreach calendar, with contact info for project/staff. Consider using your CAN's online workspace as a place to keep the calendar and outreach plan to promote regular usage and updates.*

  - *Frequency of engagement of the most vulnerable clients;*
  - *Expected volume of 211 and CAN referrals and outreach response approach and timeframe;*
  - *When case management has to be limited due to capacity constraints, targeting criteria (with CAN approval) to determine which clients will receive case management;*
  - *Approach to referrals between DOH and DMHAS teams for participants eligible for enrollment in both DOH (ESG) and DMHAS (PATH) funded outreach;*
  - *Outreach team composition, including integration of persons with lived experience of homelessness, and inclusion of or partnership with entities who can provide specific expertise;*
  - *Approach to data collection and HMIS entry, including timeliness standard;*

- *Emergency plan for natural disasters, extreme weather, and disease outbreaks;*
- *Everyday client and staff safety protocols;*
- *Public awareness/marketing plan; and*
- *Standard list of canvassing and engagement supplies*

- Outreach projects operating within each CAN geography should meet **monthly** with other outreach teams and CAN staff to review and amend the outreach plan to respond to changing circumstances, identify unmet commitments, and re-align efforts. Every **six months**, funders must review and approve the plan.

Outreach Plan Checklist

*Sample Available **Here**. Template Available **Here**.*

Alignment With all Outreach Services in CAN:

- ☐ All high priority areas are canvassed regularly and there is no duplication of or gaps in canvassing efforts.
- ☐ Participants are assigned to a primary worker in a manner that leverages individual agency strengths and resources (e.g., those with SMI get case management from an agency with clinical services).
- ☐ All outreach provider agencies convene for CAN-wide case conferencing meeting to troubleshoot case management issues, reassign participants as needed, e.g., when an agency has been unable to make progress with a participant, and assign newly identified persons for engagement.
- ☐ All outreach provider agencies convene for CAN-wide meeting to revisit outreach plan, identify gaps or duplication in efforts, and problem solve to strengthen outreach plan.
- ☐ Clearly delineates the roles and responsibilities of each outreach project operating within the CAN, as well as within a single project when sub-recipients are involved.

Canvassing When/Where:

- ☐ Includes street outreach efforts happening during early morning and evening hours, when participants are most likely to be present at their sleeping locations. Pay attention to times of day and safety.
- ☐ Includes a year-round street outreach canvassing schedule that specifies times and locations to be physically canvassed.
- ☐ Includes an office hours schedule only if office hours are utilized.
- ☐ Includes a remote canvassing schedule that establishes regular contacts or check-ins with selected community partners who have contact with people living unsheltered.
- ☐ Includes contingency planning for planned and unplanned staff absences so that engagement of those who have declined services and seem particularly unwell and/or vulnerable still occurs.
- ☐ Includes contingency planning for cold weather, heat advisories and other emergency conditions to promote participant safety.

Prioritizing Outreach Services:

- ☐ Prioritizes engagement of those who have declined services and seem particularly unwell and/or vulnerable.
- ☐ Is designed to engage populations that may be hard to find (e.g., youth, families, and remote populations).
- ☐ Includes a strategy to determine if anyone particularly vulnerable was found during the annual PIT count to ensure follow up (e.g., unsheltered families with children, youth, elderly and medically fragile).

Services Provided:

- ☐ Includes time to identify, engage, assess, and support the safety of unsheltered people who are not yet prioritized for housing; respond to public concerns regarding unsheltered people; AND provide housing focused case management services to those who have been prioritized for housing.
- ☐ Services prioritize resolving the issues that are most likely to prevent participants from quickly obtaining permanent housing.
- ☐ Services are designed to help participants build motivation for change.
- ☐ Includes strategies to address urgent physical needs: meals, blankets, clothes, and/or toiletries.

Setting Housing Targets

Projects are accountable to meet the joint **outreach outcomes**. Projects are encouraged to:

- *Establish monthly or quarterly performance targets for housing placements and other key outcomes.*
- *Determine which tasks are most critical to meet specified targets and set timelines for tasks.*
- *Track progress on outcomes, using the data to inform ongoing programmatic quality improvements (See **sample placement tracking tool** — this can be adapted to incorporate other key tasks and metrics).*

Data Entry & Data Quality

Projects are responsible for collecting and entering into HMIS all required client-level data elements. Projects should follow the guidelines below to ensure a robust, accurate data environment:

- *Use an effective system to record participant locations to facilitate tracking and sharing participant location patterns — manually entered using **HMIS Data Element 4.12** OR automatically entered using geocoding technology. Maintaining consistency in approach means that clients can be located when the primary worker is unavailable and if other community partners need to locate the client.*
- *Maintain documentation in HMIS case notes (or other system if using for pre-enrollment contacts) of consistent attempts to locate and engage all participants, including those who are eligible AND those for whom eligibility determinations have not yet been made.*
- ***Record all contacts, regardless of enrollment status,** and enter all required participant level data for enrolled participants in the Homeless Management Information System (HMIS) or a comparable data system if the agency is prohibited from using HMIS. Pre-enrollment contacts may be entered into HMIS or any database utilized by the CAN.*

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Pro tips for maximizing pre-enrollment contacts:

- *Maintain schedule of document due dates.*
- *Ask questions and build the assessment and service plan over time at a pace that works for the client.*
- *Fill out what is known, as a worker learns it through normal conversations, rather than attempting to gather information in a single session.*
- *Jot down or record notes on a phone or pocket-sized pad rather than bringing forms into the field.*
- *Scan or take photos of documents using a phone.*

- *At enrollment, record all required client-level data elements in HMIS.*
- *Employ a quarterly data quality review process to ensure data completeness and accuracy.* ***See*** *https://www.hudexchange.info/programs/hmis/hmis-guides/#hmis-data-quality for data quality improvement strategies.*
- *Refer suggestions to the HMIS Steering Committee to improve HMIS data collection and entry efficiency, availability and usefulness in informing service delivery.*
- *Enter data in HMIS/other database within 24 hours after being in contact with a client.*

Documentation

DOH Eligibility Standards:

Enrollment limited to clients who lack a fixed, regular, and adequate nighttime residence, meaning: Has a primary nighttime residence that is a public or private place not meant for human habitation; OR Is exiting an institution where (s)he has resided for 90 days or less and who resided in a place not meant for human habitation immediately before entering that institution.

PATH Eligibility Standards:

Enrollment limited to clients determined or suspected to be experiencing serious mental illness OR co-occurring serious mental illness and substance use disorders.

Participants determined to be ineligible for PATH services must be referred to appropriate services, including but not limited to DOH Street Outreach team.

Projects are responsible for maintaining case records and other written materials that demonstrate funder required activities are taking place, including evidence of the following:

- Concrete plan for engagement and determining eligibility as quickly as possible for each participant.
- [PATH ONLY] Disability has been documented for all enrolled participants.
- Consistent attempts to locate and engage all participants, including those who are eligible and those for whom eligibility determinations have not yet been made.
- Outreach service provision is in accordance with outreach plan.
- Participants are connected to services to address health, mental health, addiction, educational, and vocational needs and assisted to use community resources (e.g., schools, libraries, houses of worship, grocery stores, laundromats, parks, etc.
- Each participant has a needs assessment and **service plan** that:

Note: *Service planning begins by asking people what they want, helps them define their desires and interests, establishes a vision for what they want out of life, and builds hope that those things are possible. Outreach staff then design services to help clients achieve their goals.*

  - *Follows the Assessment and Service Plan template.*
  - *Was created within 30 days of project enrollment.*

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- *Is updated at least every 90 days.*
- *Is signed by the participant, outreach worker and supervisor o Includes specific and measurable goals (service plans).*
- *Includes action steps, who is responsible, and timeline to complete (service plans).*

- Participants are connected to appropriate on-going services in advance of planned discharges.
- Participants are discharged from the project only for **permitted reasons**.

Permitted reasons to discharge a client:

Outreach staff have been unable to make contact with the participant in the past 90 days.

Participant was placed in permanent or transitional housing more than 90 days ago.

Participant has been institutionalized for a period anticipated to be longer than 90 days (including hospitalization, jail, prison, and residential treatment).

Participant is deceased.

Participant has been transferred to a different project to receive case management and housing placement services.

Participant has requested to be discharged.

Safety Protocols

Project maintains safety protocols for frontline staff that include guidelines to maximize client and staff safety in all outreach-related interactions, including at a minimum:

- Required notice (to whom) of where/when canvassing will occur and how often staff will check in.
- Required trainings, e.g., in de-escalation techniques and other necessary personal safety skills.
- Under what conditions staff are paired or solo while canvassing.
- Under what conditions clients may/may not be transported while staff are canvassing .
- Incident debriefing, reporting, management, and follow-up.
- See **Safety Checklist for Frontline Staff and Supervisors** for more concrete details.

Client Surveys

- Project surveys some percentage of clients at least annually using the consumer survey instrument available in **English** and **Spanish**.
- Project reviews client survey results and takes action accordingly.

Guidelines for Agencies Receiving Street Outreach Funding

Section 4

Guidelines for Agencies Receiving Street Outreach Funding

Agencies administering Outreach projects are monitored on the guidelines in this section.

Agencies, whether direct or subcontracted recipients of DOH or DMHAS funds, are responsible for creating and maintaining a non-discriminatory workplace and service provision environment; maintaining an internal quality assurance process; maintaining policies and procedures that govern agency and project operations; ensuring that homeless services programs are meeting the unique needs of marginalized communities; and conducting internal monitoring of Street Outreach projects on their contract compliance and performance.

Prime Contracting Agency Responsibilities.

- Maintaining an agreement or MOU between the prime and each subcontracting agency that covers expectations of service deliverables, project outcomes, and data collection.
- Conducting regular check-ups with subcontractors during the contract lifecycle to ensure that contractual expectations are being met.
- Submitting funder required reporting on time.

Required Policies and Procedures for Prime and Sub Agencies.

- Indicate full compliance with all federal and state nondiscrimination laws and with the rules and regulations governing fair housing and equal opportunity in housing and employment, including reasonable accommodation provisions
- Address conflicts of interest, including:
  - *Policies requiring staff and Board members to disclose conflicts of interest and prohibit financial interest or benefit from PATH assisted activity on the part of staff, persons with whom the staff member has immediate family or business ties, and Board members during their tenure with the organization and one year following their tenure*
  - *Procedures to mitigate any conflicts of interest that are present*
- Define agency expectations of staff conduct, including guidance on professional boundaries.

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- Define agency expectations of staff conduct, including guidance on professional boundaries.
- Ensure that all participant records containing identifying information are kept secure and all information is handled in a manner that protects participant confidentiality.
- If applicable to the population served, ensure that participants are helped to understand their educational rights, that children and youth are immediately enrolled in school, as required by federal and State law, and that they are connected to educational services to help them succeed in school.
- Include a written grievance policy that (1) defines a process that is accessible to participants with low literacy levels and other barriers; and (2) is posted in an area readily visible to project participants who are receiving services at the agency offices.
- Designate a Client Rights Officer to manage the grievance process.
- Ensure that grievance reviews are conducted by a person other than someone who made or approved the decision under review or a subordinate of such a person; and that outreach participants are informed in a timely manner of the outcomes of any grievance.
- Address staff safety and critical incidents — see Supervisory Checklist for concrete steps.
- Address critical incident reporting and management, including:
  - *Defining a critical incident*
  - *Outlining procedures for critical incident reporting*
  - *Outlining procedures for critical incident management*

Agency-Level Diversity, Equity and Inclusion Efforts.

Agencies (prime and sub) are responsible for taking concrete actions to ensure that homeless services programs are meeting the unique needs of marginalized communities, including people with lived experience of homelessness; people who identify as Black, Indigenous, and People of Color (BIPoC); LGBTQIA+; and people from nations of origin and linguistic groups that are significantly represented in the relevant CAN. Some actions to consider are listed below:

- Recruiting, retaining and promoting people with lived experience of homelessness in staff and Board positions.

Continue...

Continued...

- Recruiting, retaining and promoting people who identify as BIPoC, LGBTQIA+, and/or people from nations of origin and linguistic groups that are significantly represented in the relevant CAN in staff and Board positions.
- Creating and maintaining an inclusive organizational culture that promotes equity.
- Improving opportunities for people with lived experience of homelessness to shape homeless services programs.
- Incorporating restorative justice practices into homeless programs.
- Developing partnerships with local organizations that focus on work with marginalized populations.
- Analyzing who gets access to your agency's homeless services programs and program outcomes by race/ethnicity/sexual orientation/gender identity to determine if access and/or outcomes are disparate.
- Planning and implementation of steps to address any disparate access or outcomes.

*See **Race Equity Framework for the Connecticut Homeless and Housing System.***

Agency Guidelines for Supporting Street Outreach Projects.

Agencies (prime and sub) are responsible for supporting outreach projects through:

- Establishing and funding a Street Outreach supervisory role that meets **Supervisory Guidelines**.
- Ensuring that outreach staff have access to regular clinical consultation or supervision to help identify signs of serious health challenges, mental illness, and substance use disorders in clients, and adjust interventions accordingly.
- Ensuring that supervisory and outreach staff are adequately trained on **relevant topics**; including connecting with partner agencies, CoC(s), funders and other organizations offering training opportunities, and regularly communicating opportunities to project staff.
- Setting reasonable projections of numbers served and expectations for caseloads that reflect staff time commitments for canvassing, engaging, providing housing focused case management, coordinating with partners, completing documentation and data entry, and other activities that support permanent housing placements.

- When constraints or unique circumstances impact service delivery, agency seeks alternative service guidelines with funder and/or narrows priorities for outreach project.
- Developing partnerships and, where feasible, establishing MOUs or other formal agreements with partners who can provide expertise or resources to support the Street Outreach project.
- Actively participating in the Continuum of Care (e.g., attending meetings, ensuring that outreach project participates in annual PIT counts, participating in relevant workgroups and committees, etc.)
- Working with funders to secure additional resources for low-barrier, immediate, safe bridge housing for persons unwilling to use ES or TH.
- Educating all agency staff on welcoming and respecting clients living unsheltered, including adopting a culture of saying "yes" to people's requests whenever possible, e.g. charging a phone, using the restroom, and other requests that ease the daily burden of living unsheltered.
- Developing and maintaining an emergency/disaster preparedness and response plan that includes:
  - *Risk assessment protocols to identify potential crises — natural disasters, disease outbreaks, and other emergencies — on which to focus planning efforts.*
  - *Identification of and plan to coordinate with relevant partners: Disease/public health: local and state public health departments; local and state emergency management, healthcare providers, and other key partners.*
  - *Natural disasters: local and state emergency management, municipal services, law enforcement, and other key partners.*
  - *Emergency protocols to minimize impact on or loss of staff and client lives, property and records.*
  - *Plan for communicating to staff, clients, volunteers, board, funders, partners, and the public during an emergency to reduce uncertainty, protect client confidentiality and address rumors and fears — when applicable, relying on messaging from national, state or local authorities like CDC, state emergency management, health department, etc.*
  - *Emergency protocols to maintain continuity of critical services and to resume services when an unavoidable break occurs.*
  - *Steps and timeline for post-crisis evaluation and necessary plan revisions.*
  - *Protocols and expectations for training outreach staff to follow the plan.*

Suggested Training Topics for Agency Staff.

Agencies are responsible for ensuring that all staff participate annually in at least 12 hours of training on topics that will help them improve their street outreach service provision.

Topics could include:

- Outreach and engagement best practices.
- Housing First techniques to begin planning for successful, sustainable housing from Day 1.
- Housing-focused assessment and service planning strategies.
- Psychiatric First Aid and Mental Health 101.
- Recognizing survivors of domestic violence, sexual assault, or human trafficking and how to ensure safety and access to care through DV provider referrals, crisis hotlines, etc.
- Cultural and developmental competence and specific risk factors for transition aged youth (TAY) and young adults experiencing homelessness.
- Cultural competence and specific risk factors for LGBTQIA+ persons experiencing homelessness.
- How trauma impacts the brain and body, how post-trauma response impacts behavior and functioning, impact on staff of serving clients with trauma.
- Trauma Informed Care evidence-based practices to respond to persons who have experienced trauma.
- Motivational interviewing; how to identify ambivalence and collaborate toward greater self-efficacy and goal-directedness.
- Harm reduction techniques as applied to unsheltered homelessness.
- Crisis prevention and intervention protocols, including techniques for de-escalating disruptive or violent situations, when to call 911, identifying signs of overdose, responding to overdose, use of Naloxone, locating detox beds, contacting mobile crisis and suicide prevention, contacting victim services, contacting hospital social workers.
- Assertive engagement techniques for working with persons with severe or persistent mental illness or substance use disorder, including identifying/responding to signs of mental illness and addiction.
- Coordinated Access Network (CAN) structure, policies, assessments, by-name lists and referral process.
- Coordinated Access Network and HMIS data entry.

Appendix

Appendix A: Performance Guidelines

These outcomes and metrics directly measure progress on the statewide outreach goals. Taken as a whole, they reflect the state's vision for street outreach to play an important role in ending unsheltered homelessness in CT. If you're a project administrator, you'll need to regularly look at the project's progress on these metrics and refocus efforts on areas where performance is falling behind. Below are two sets of metrics. The first set is outcome-based performance standards that providers will be measured against in monitoring. The second set is recommended for projects' internal usage.

Outcome Based Performance Guidelines*	
1.1	% of clients exiting SO project who exited to a permanent housing location
1.2	For clients who exited to a permanent housing location, length of time from enrollment date to permanent housing move-in date
1.3	% of clients with increase in income from any source from enrollment to exit, regardless of exit destination
1.4	% of unsheltered persons encountered (regardless of enrollment) who are entered into HMIS** within 72 hours of encounter
**DOH and DMHAS will collect baseline data for FY 22-23 and establish targets for the following year based on the baseline data.*	
***SO contacts pre-enrollment are not held to HMIS Data Quality standards; however, all data elements are expected to be collected by the time of enrollment*	

Internal Performance Guidelines	
2.1	% of clients on SO high priority list exiting SO project who exited to a permanent housing location
2.2	% of referrals from 211 or community partners are successfully contacted within 24 hours, or due diligence is documented for those unable to be located
2.3	% of unsheltered persons encountered (regardless of enrollment) who are provided with information on health, education, housing, budgeting, and/or other services, in order to enable them to make informed decisions on meeting their needs, as evidenced by comprehensive case notes
2.4	% of enrolled clients with complete HMIS records, including Location Details in 4.12 "Current Living Situation" and/or case notes that contain detailed description of client location
2.5	Of SO clients who have a housing move-in date, % with HMIS client records that reflect continuous SO enrollment and monthly SO case manager check-ins for 90 days after housing move-in

Appendix B: Outreach Plan Template

PATH Recipient Agency:	
PATH Sub-Recipient Agency(s):	
DOH Recipient Agency:	
DOH Sub-Recipient Agency(s):	
CAN:	
Geographic Area Addressed in this Plan:	

Canvassing Schedule. *Provide details on outdoor locations where outreach workers are most likely to encounter unsheltered homeless people. Specify who is assigned to canvass these locations and when canvassing will occur. Be sure to include locations where outreach workers are likely to encounter all relevant populations (e.g., young people, undocumented immigrants, families with children, etc.). In CANs where multiple agencies provide outreach services, include all agencies. Add/delete rows as necessary.*

Day	Time	Location	Agency Assigned	Staff Assigned
Example: Mondays	*7am-9am*	*Train Tracks Behind Walmart*	*Hope House*	*Mary & Tim*
Mondays				
Tuesdays				
Wednesdays				
Thursdays				
Fridays				

Office Hours Schedule. *Provide details on indoor locations where outreach workers are most likely to encounter unsheltered homeless people. Specify who is assigned to visit these locations and when visits will occur. Be sure to include locations where outreach workers are likely to encounter relevant populations (e.g., young people, undocumented immigrants, families with children, etc.). In CANs where multiple agencies provide outreach services, include all agencies.*

Day	Time	Location	Agency Assigned	Staff Assigned
Example: Mondays	*7am-9am*	*Maple Street Library*	*Project Help*	*Kim & Sue*
Mondays				
Tuesdays				
Wednesdays				
Thursdays				
Fridays				

Engagement Plan for Most Vulnerable Clients. *Indicate specific clients (initials and/or HMIS #s only) who are highly vulnerable, who is assigned to engage them and how frequently engagement attempts will occur. Add/delete rows as necessary.* ***NOTE:*** *This should be a brief list of ONLY clients determined by the CAN to be highly vulnerable. It is not intended to be a complete list of all PATH clients. In CANS where multiple agencies provide outreach services to the most vulnerable clients, include all agencies.*

Client	Agency Assigned	Staff Assigned	Frequency
Example: JOFI (HMIS #12345)	*Hope House*	*Mary & Tim*	*At least 2x/week*

Case Management Plan.

Project provides Case Management, including needs assessment and service planning, for all PATH enrolled clients?

☐ Yes ☐ No (If *no*, please also complete sections below.)

Project has received DMHAS approval to provide Case Management for only a subset of all PATH enrolled clients?

☐ Yes ☐ No

DMHAS has approved limiting the clients for whom the project provides case management to the following number:

Number: # *(Please Provide the Point-in-Time #)*

The CAN has approved the following targeting criteria to determine for which clients the project will provide case management (check all that apply):

- ☐ Target clients who have been determined by the CAN to be the most vulnerable.
- ☐ Target clients who have been determined by the CAN to have been homeless the longest.
- ☐ Target clients who have been prioritized by the CAN to receive a housing intervention.
- ☐ Target clients who have expressed willingness to participate in case management services while continuing regular attempts to engage others.
- ☐ Other approved targeting criteria (specify):

Phone/Email Outreach Schedule. *Provide details on towns where neither in-reach nor canvassing is feasible. Specify people who can identify and refer any unsheltered homeless people in each town, who is assigned to stay in contact with to each person and how frequently contact will occur. In CANS where multiple agencies provide outreach services, include all agencies. Add/delete rows as necessary.*

Town	Contact Info	Agency Assigned	Staff Assigned	Frequency
Example: Harleysville	***Joe Smith (Mayor's Assistant)*** *(201)-555-111* *jsmith@hville.gov*	*Project Help*	*Kim*	*Quarterly*

Schedule for Other Critical Staff Tasks.
Identify and schedule other critical tasks that outreach staff need to prioritize. In CANS where multiple agencies provide outreach services, include all agencies.

Task	Agency Assigned	Staff Assigned	Days/Times
Example: Documentation	*Project Help*	*Kim & Sue*	*Tuesdays, Thursdays, & Fridays (7am-10am)*
Example: Case Management Tasks with Enrolled Clients	*Hope House*	*Mary & Tim*	*Mondays (9am-12pm) Tuesdays, Wednesday, & Fridays (12pm-3pm)*

Coverage Plan. *Briefly describe:*
A) The project's strategy for ensuring that regular outreach occurs during planned staff absences.
B) The project's strategy for ensuring that engagement of those who seem particularly unwell and/or vulnerable occurs during unplanned staff absences.

A:

B:

Uncovered Areas. *Briefly describe:*
A) Any geographic areas within your CAN that are not covered in this plan and the reason why.
B) Any plans your project or CAN has to ensure that all areas are covered in the future.

A:

B:

System Gaps. *Briefly describe:*
A) Any key organizations or sectors within your CAN that are not currently engaged to help prevent and end unsheltered homelessness (e.g. Shore Hospital, Fulton County jail, DOC, child welfare, schools, etc.)
B) Any plans your project or CAN has to ensure that these partners are engaged in the future.

A:

B:

Engagement Supplies.
List supplies that are available to outreach workers to offer to clients. Examples might include toiletries, socks, gloves, hats, blankets, water, etc. If needed supplies are not currently available, describe plans for obtaining supplies.

Public Awareness/PIT. *Briefly describe:*
A) The project's strategy for ensuring that members of the public who are unfamiliar with the homeless services system know who to call to get help for a homeless person.
B) How your project prioritizes and responds to such concerns.
C) How your project determines if anyone particularly vulnerable was found during the annual PIT count and how you follow up to engage those people.

A:

B:

C:

Plan Renewal and Approval		
Supervisor Name:	**Supervisor Signature** *(required monthly):*	**Date:**
	Month 1:	
	Month 2:	
	Month 3:	
	Month 4:	
	Month 5:	
	Month 6:	
CAN Representative Name:	**CAN Representative Signature** *(required 2x/year)*	**Date:**
	Period 1:	
	Period 2:	
DMHAS Representative Name:	**CAN Representative Signature** *(required 2x/year)*	**Date:**
	Period 1:	
	Period 2:	

Appendix C: CT PATH Assessment & Service Plan Template

Instructions:

- CT PATH projects are required to complete an assessment of client service needs and an initial service plan within **30 days of participant enrollment.**
    - *If a project has insufficient case management resources to enable service planning with all enrolled clients, the project may propose an alternative case management plan to DMHAS (e.g., conduct service planning with the 20 clients determined to be most vulnerable and/or homeless the longest).*
    - *That alternative plan must be documented on the project's outreach plan, which must be approved by DMHAS & the CAN.*
- Assessments and service plans must be updated at least every 6 months; but every 2 months is recommended, especially during the housing access process.
- All assessments and service plans must be signed by the participant, outreach worker and supervisor.
- Goals must be client-driven, specific and measurable; and plans must indicate who is responsible for indicated action steps and when those action steps will occur.
- CT DMHAS has provided a template on the following pages that meets these requirements. PATH projects are required to use this template.
- The template provides space for **up to** three goals. Participants should determine how many goals they choose to focus on.
    - *PATH projects are discouraged from working with participants on more than three goals simultaneously and encouraged to include at least one housing-related goal.*
- This template is intended to be used as a supplement to the Statewide PATH HMIS Assessment form, which is used currently to gather data required in HMIS.
    - *Outreach staff should review the information gathered on that form in advance of establishing and updating service plans.*
- PATH projects are required to make assertive attempts to engage clients receiving case management services in the assessment and service planning process. Clients may opt not to participate. In such circumstances, projects should document engagement attempts.
- An example of a completed Assessment and Service Plan is available for training purposes at https://www.ctbos.org/resources/.

PATH Assessment & Service Plan Template

Participant Name:

Plan **Start** Date: Month Day Year

Plan **End** Date: Month Day Year

PART 1: ASSESSMENT	
What is the person's plan to end their homelessness?	
What motivates this person to obtain/ maintain housing?	
What is the person's long-term goal and how will housing help with that goal?	
When was the last time this person had a permanent place to live?	
Describe that place:	
Describe how person lives/sleeps now. For example, sleeps in a tent in a camp with other people; bounces between hotels, friends, family; sleeps behind the church.	
Factors that led to homelessness:	
Did the person ever serve in the U.S. military?	YES NO

People Who Provide Support (Name, Relationship, & Contact Info)	
Emergency Contact (Name, Relationship, & Contact Info)	

PART 1: STRENGTHS & SUPPORTS SUMMARY	
Income and Financial:	**Mental Health and Substance Abuse:**
Employment:	**Family and Support:**
Housing:	**Skills:**
Health:	**Education:**
Other:	
What strengths/supports will be most helpful in the housing access and stabilization process?	

PART 1: BARRIERS SUMMARY

Income

- [ ] No income
- [ ] Insufficient income to afford housing
- [ ] Recent decrease in income
- [ ] Receiving unemployment or other income that is time-limited
- [ ] Sanctioned or timed out on benefits

Mental Health and Substance Abuse

- [ ] Monthly obligations exceed monthly income
- [ ] Poor credit history
- [ ] Currently in bankruptcy
- [ ] Subject to Child Support Enforcement – e.g., "garnish wages"

Education and Employment

- [ ] No High School Diploma or GED
- [ ] Unemployed
- [ ] Currently in temporary or seasonal job
- [ ] Inconsistent work history – gaps in employment or frequent changes in jobs

Legal Issues

- [ ] On parole
- [ ] On probation
- [ ] Felony in last 5 years
- [ ] History of violence
- [ ] Current legal involvement
- [ ] Needs immigration status advice

Housing History

- [ ] Multiple episodes of homelessness
- [ ] One or two legal evictions
- [ ] More than 2 evictions
- [ ] Never had own lease
- [ ] Evicted from subsidized housing
- [ ] History of institutional care – e.g., state hospital, foster care, prison

Family Status

- [ ] Current or past involvement with foster care system
- [ ] Has children in foster care
- [ ] Domestic violence survivor
- [ ] Current involvement in abusive relationship
- [ ] Subject to Order of Protection

Health/Disability

- [ ] Chronic physical illness
- [ ] Health crisis, detox or hospitalization in the past year
- [ ] Multiple hospitalizations in past year. #:
- [ ] Ongoing medical needs and no health insurance
- [ ] Multiple disabling conditions
- [ ] Disabling condition has negatively affected community stability
- [ ] Not in treatment for ongoing issues

Supports/Independent Living Skills

- [ ] No ID
- [ ] No or limited support networks
- [ ] History of being unable or unwilling to seek help
- [ ] Limited English proficiency
- [ ] Literacy problems
- [ ] History of problem visitors
- [ ] Hoarding problems
- [ ] Inadequate financial management skills
- [ ] Other gaps in Independent Living Skills, specify:

PART 1: BARRIERS SUMMARY (CONTINUED)

What are the most significant barriers to housing access/stability?

What are the most significant issues that interfere with this person's safety/wellbeing?

Other Comments:

PART 2: SERVICE/HOUSING STABILIZATION PLAN

Type of Plan:	◯ Initial Plan ◯ Update	Date of Plan:	From: To:

Goals from Previous Plan (If Applicable)	Status Achievements & Barriers
1	
2	
3	

PART 2 GOALS: Establish and Prioritize Goals Based on Current Assessment and Risk Factors

Goals (for this assistance period)	OUTREACH STAFF TASKS	TARGET DATE	PARTICIPANT TASKS	TARGET DATE
Goal 1: Check Area: ☐ Housing Stability ☐ Financial, ☐ Health/Mental Health ☐ Substance Use ☐ Family & Friends ☐ Life Skills				
Goal 2: Check Area: ☐ Housing Stability ☐ Financial, ☐ Health/Mental Health ☐ Substance Use ☐ Family & Friends ☐ Life Skills				
Goal 3: Check Area: ☐ Housing Stability ☐ Financial, ☐ Health/Mental Health ☐ Substance Use ☐ Family & Friends ☐ Life Skills				

Participant Signature:		**Date:**	
Staff Signature:		**Date:**	
Supervisor Signature:		**Date:**	

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