
Providing Services in Permanent Supportive Housing Connecticut, 2025



Agenda

- Introductions
- Approach to PSH
- Organizing Principles
- Service Provision

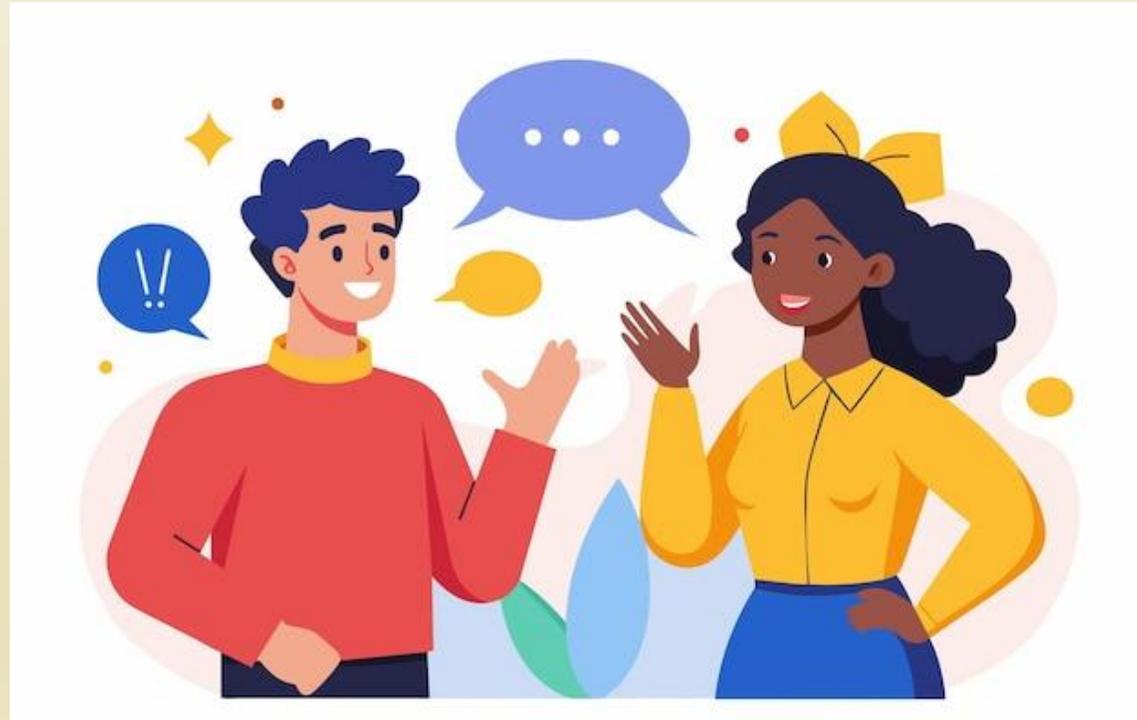


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 - Phylcia Adams – CSH
 - Andrea White – HI
 - Brenda Earle – DMHAS



Introduce Yourself

Find someone you do not know. Introduce yourself (name, affiliations, location etc.) and talk for two minutes each about why you came to this session.



Introduction



- Participants in PSH have a variety of life experiences that can affect how they approach housing, tenancy and services
- Long-term homelessness, post traumatic stress disorders, family/partner violence, substance use, and mental illness are some of the experience's participants may have
- PSH programs are designed to assist people to establish a base in the community, educate on rights and responsibilities, teach skills necessary to meet tenancy obligations, access needed resources and problem solve to reach self defined goals
- This requires tenants, services and housing providers to work together, to understand the approach and to clearly define roles and expectations of the service
- [CT PSH QI - Domain & Scale](#)

The Approach



- The approach that PSH programs take in Connecticut is focused on fair access and participant choice.
- The goals of the service are programmatic, such as Housing Stability and connections to services appropriate to each tenant's needs
- The goals are individualized to each tenant and reflect the longer-term goals and preferences that tenants identify
- Choice is important and reflects how each tenant wants to address a challenge or to strive for goals. We take a trauma informed approach to reflect tenants' experience. Choice has to include the possibility of moving on, using PSH as a launching pad
- There is a structure to PSH which prepares each tenant to live more independently in the community

Housing as Base for Recovery

Housing is recognized as the base.

- Tenants are not expected to be “housing ready” the services delivered through PSH are expected to connect tenants to resources, teach skills and teach problem solving
- Services are offered to assist tenants to meet the expectations of housing and connect to resources
- The expectations of housing do not change and learning tenancy is PSH gives each tenant a choice of housing in the future
- Though tenants do not have to accept all services offered, tenants must meet the expectations of housing – this is not everything goes.
- Tenants must have a process to address any lease issues, termination must be a process and assistance offered

- **Discussion**

Principles of a Trauma-Informed Approach*

1. Safety

2. Trustworthiness and Transparency

3. Peer Support

4. Collaboration and Mutuality

5. Empowerment, Voice and Choice

6. Cultural, Historical, Racial and Gender Issues

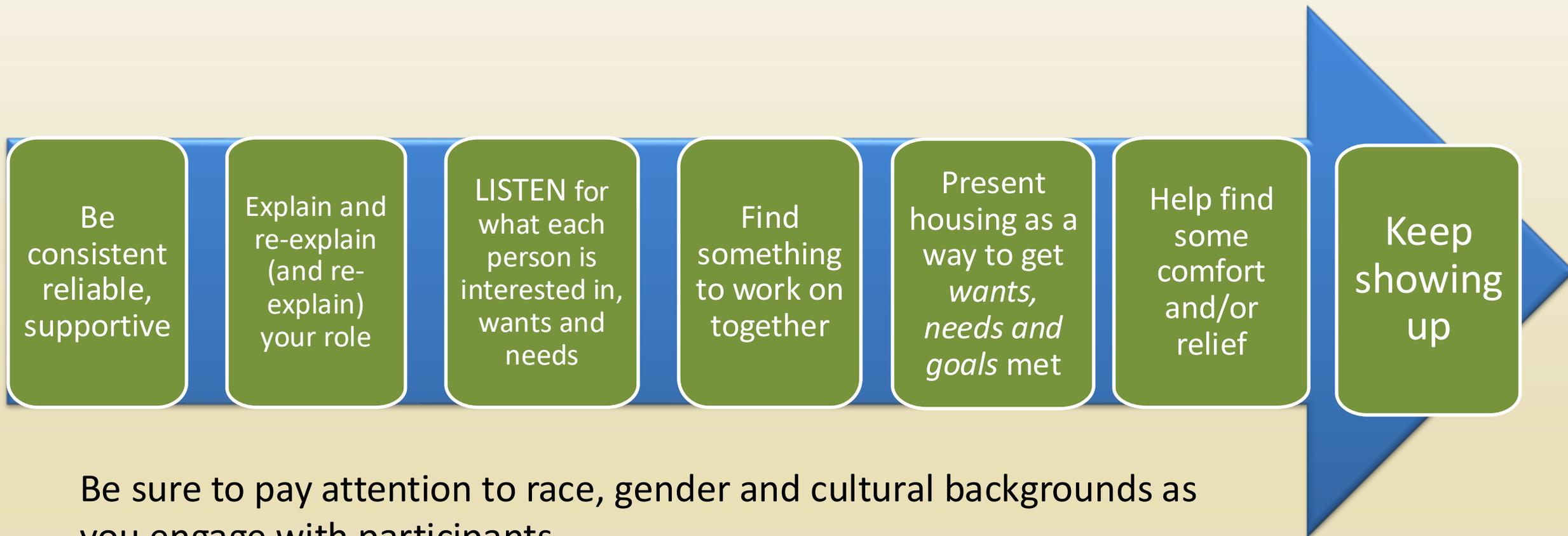
*Adapted from SAMHSA Trauma Informed Care



Separation of Roles: Property and Services

- The function of Property and services are separate to teach tenancy skills, don't create an alternate environment.
- Property Manager make clear the expectations of the lease and assist tenants to meet these expectations through consistent and fair enforcement and working with the tenant/services team to teach tenancy skills
- Services helps tenants meet the expectations of housing but does not enforce the lease. Services through training, planning and identifying resources to meet tenant needs helps tenants to be stably housed and to meet their life goals

Key Areas of Services Intervention -Engagement



Be sure to pay attention to race, gender and cultural backgrounds as you engage with participants.

Points for Engagement

- Try to get a warm handoff from previous services such as shelters
 - A warm handoff is an opportunity to describe the PSH program and roles, PSH is for people who need services.
 - A warm handoff can transfer some of the engagement from the previous worker
 - A warm handoff is a good opportunity for Tenants to talk about their work in the shelter, identify what they are good at, and plan for future work together





Goals and Motivation

- Goal setting is key to engagement and planting the seed for motivation. It is important that people have goals they can feel, that they can strive for
- [Service Plan Template](#)
 - There is no ambivalence between a person's behavior and program goals
 - In order for people to want to change they have to want to
 - Ask the question the "so that" question.
 - You want to see a Doctor so that? or What are some reasons that someone might get psychiatric care
 - You have housing what do you hope will happen?
 - Stopping using is a great goal, what do you hope to gain from this?

Breakouts: Goals Discussion (Groups of 3)



One person will share an example of something a participant wants to set as a personal goal or give an example of a goal of your own (simple, not too personal)

One person is the worker and has the “so that” conversation to find out:

What are the reasons behind this goal?

“So that” what?

Try to elicit from the participant, “I want to so that”

The third person is the observer and gives feedback to the other two and reports back on the conversation

Assessment

- Assessments must be completed at least every six months; however, assessments unfold over time and acuity changes.
- It is not expected you get all the information at once, it can take several visits
- Though the entire assessment does not have to be updated more than annually we must be prepared to note the information of changes so the information can be used.
- Assessments and acuity are designed to be living documents



Assessment and Acuity Assessment

- The assessment and acuity scale covers a wide range of issues that affect people's life in the community.
- It identifies challenges and strengths and allows for prioritization of issues to address.
- There is more detail and training available on [Link to trainings](#) & [List of DMHAS PSH Recorded Trainings](#)
- There will be a self paced training module on the DMHAS LMS system.
- [Assessment & Acuity](#)
- Discussion of Assessment and Plan

Understand Housing and Homeless History and **Goals**

Housing History –

Places lived, with whom (last 5 years)

Experience as a leaseholder

Roles and responsibilities

What worked/what didn't

Satisfaction with current housing

Housing goal(s)

Homelessness History -

Cause of initial episode

Length of time homeless

Places stayed

Routine

Supports



Housing Stabilization Services



- Focus on Resources: focus on high quality sustainable resources
 - The case manager can not be the nexus of tenant's lives
 - People with mental illness, substance use disorders and HIV need access to high quality clinical services
 - Full access to these resources often requires the help of DMHAS, supervisors and agency senior staff
 - The case managers role here is to make a good connection, teach connecting skills and monitor the work
 - [Tenant Resource List](#)
 - [Mental Health Resources](#)
 - [Substance Use Resources](#)

Teach Skills



- Consider classes that teach skills such as Tenancy Classes, reading and job skill classes, computer classes, access to resources or a newsletter that defines resources, cooking classes, pet care classes.
- We are working on improving feelings of competence so that tenants may try these services outside the site. Give certificates, discuss strengths, encourage tenants to use skills to assist others.
- Model skills, accompany to appointments, model access and negotiation, model negotiating for needs, recognize competence

Create Norms for Behavior

- **Agreement** on which positive behaviors are re-enforced and which behaviors are considered disruptive or not consistent with community values and mission.
- **Consistency of** all staff initially and eventually most participants in the community. The staff models the behavior and as participants see the change, they often will reinforce the values
- **Reasonable** behavioral expectations based on a discussion of how said behavior either positively or negatively affects the community.
- **Rewarding** both positive behavior and behavior change through time and attention.

[Norms Overview](#) & [Norms Planning Worksheet](#)

Creating norms around safety and respect

What behaviors do you support/reward?

- Kindness
- Helping other tenants or staff
- Having a plan and using it to regain control
- Using established ways for grievances or appeals
- Contributing to plan
- Following up with agreed upon tasks
- Respecting others
- Following the rules or the lease
- Others?

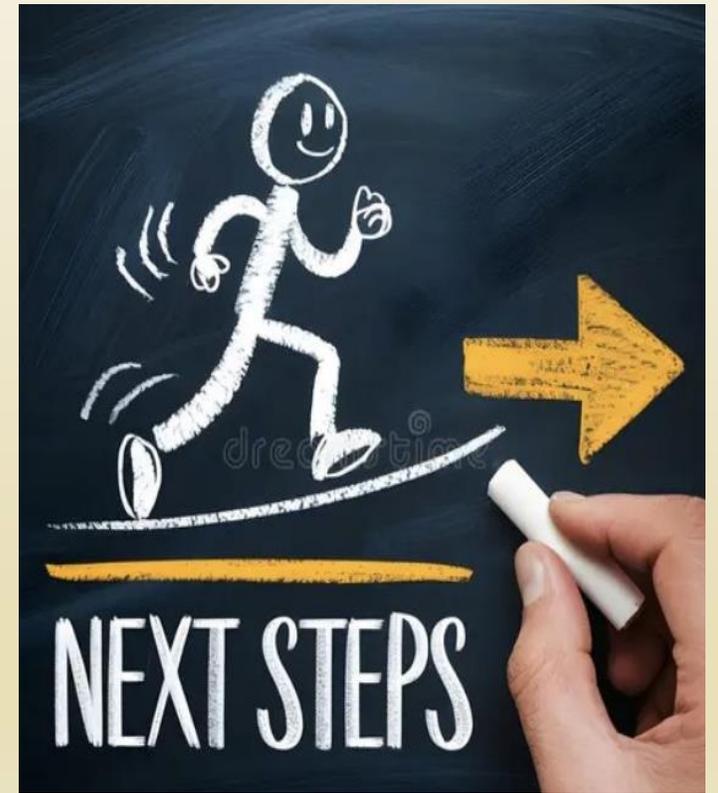


How are they supported?

- Recognizing them in a conversations
- Time and attention
- Following through when people use established ways to resolve problems
- Asking them to share the process in groups
- Write them a letter or recognize with award or certificate
- Mentoring and modeling these behaviors
- Sticking to a predictable process (e.g., if people follow the lease for two months they get a letter acknowledging this)
- Others?

Next Steps

- Make a plan about how to train new staff and how the training resources can be best used in your programs.
- Some programs use pieces of training in team meetings, watch the sessions together and discuss, rely on shadowing and peer training with session back up, mostly programs use a combination.
- Consider offering a community of practice with clinical support to discuss cases that may be challenging and also Tenants what are doing well.
- The afternoon session will go in depth on service planning and resource development
- Lunch!



Service Planning Process Permanent Supportive Housing April 2025



Introductions

- Welcome Back
- Recap of Morning Session
- Feedback on Networking Lunch



Agenda



Introduction to Session

Service Planning and Case Note Break Out

Service Planning

Case Notes

Larger Group SP and CN breakout

Resources Break Out

Implementing in your program

Introduction



- The service plan guides the work with each individual PSH tenant and the case notes guarantee continuity of care and supervision
- [Service Plan Template](#)
- The plan is a working document that evolves with each person
- The plan is developed from the on-going assessment, tenant input and goals, discussions with the team and community resources and the work together.
- Service planning can provide the structure for each person to reach goals, address barriers in the future and increase opportunities for more independent living

Case Note

- Focus of the Intervention: What is the Tenant Presenting
- Assessment of Issue and Connection to Service Plan
- Intervention by Tenant and Worker
- Plan to Move Forward and next steps

- Signatures
- Supervisor sign off





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- Break up in groups of 5 or more
 - Read the Assigned Acuity assessment
 - Develop a Housing Plan Based on that Assessment
 - Develop a case note based on the plan and your interactions with Tenants

Service Planning Process - reminder



Focused Service Planning

Limit the areas of
intervention

Connect to
Acuity scale

Focus on pressing
needs that impact
Housing Retention

Relate all
interventions to
long term goals

Be aware this
may not be a
linear process

Connect to
sustainable
resources

Smart Goals



Specific	Goals are specific and detailed. Focusing on one task / issue at a time
Measurable	Markers are set to identify progress and trigger reframing
Achievable	Goals are realistic and can be accomplished in time frame
Relevant	Reflect the input, values and priorities of participants
Time Based	Set realistic but aspirational time frames

Strategies to Reach Goals

Just as goals are individualized so are strategies towards goals

One path will not work for all people, it has to be right for the tenant you are serving

As we identify strategies we are not always going to find the most effective one on the first try

We may know in our experience what will work best, and each tenant will be able to identify what will work best from their experience

We have to try to come together, honoring each tenant's individual experience

Review Service Plans



Housing Planning and Case Note Exercise

- All groups with Acuity 1, 2, or three join together
- Review you previously completed plan
- Discuss combining plans into one and any changes you may make
- Discuss the case note previously completed in the larger group
- Combine notes and report on any changes to the notes
- Report back for larger group discussion
- Combined Plan and Note, Any Changes, Discussion, Would you do things differently going forward?



Motivation



Recognize Competence: Identifying skills that will help people access and maintain housing is important.

Person Centered: Rank the importance of needs and goals connect addressing barriers to the things persons find most important

Reflect information to affirm it is heard: This may be the start of the conversation.

Address barriers in context of goals (housing, employments, money)

Support Choice: acknowledge choice and always try to explore more than one option.

Educate on Resources and Services

- Teach the rights and responsibilities of the participants to the service
- Explain the services offered and process to access the services
- Practice asking for the services needed
- Mentor each person through the access and work with each service. Stay in touch, connect to advocacy such as PT. services.
- Explore and address fears or reluctance that may be based on previous experience. Listen to their concerns:
 - Psychiatrists will not hospitalize people or force medication unless this person is a danger. These are your rights, and we will advocate together
- Make the right match
- BE prepared to re-negotiate connections



Goal Based Strategies

- Work from each person's own experience and values
- Find out what is in it for them!
- Elicit and listen to the person and reflect back to clarify and check understanding
- Goal setting is an individual process
- Empathize about goal setting and unmet goals
- Listen to resident's perception of past successes and struggles in reaching goals
- List and discuss strengths that may facilitate reaching goals



Establish Links to Resources

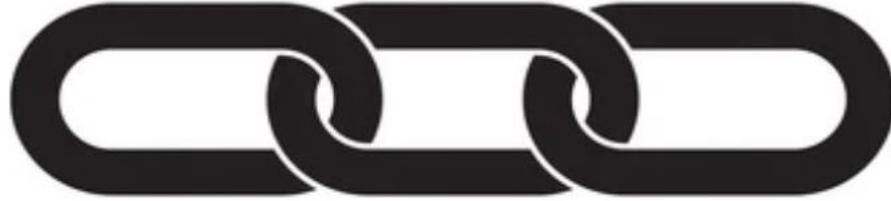
- Ensure knowledge of them – directory, visits to programs, ask users of the service for feedback, know goals of the service and what they provide
- Introduce yourself and your service, especially if there will be a lot of referrals and identify how you can help them meet their goals, maybe MOU's
- Explain your role and what they can expect
- Gather and share history (with consent) and attempt coordinated planning
- Offer to accompany each person to assist with engagement with a new service
- Maintain regular contact to see how things are going
- Keep your promises
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Connecting to Resources



- Role of the case manager is to focus on their current needs and set participants up to address the issues as they arise in the future.
 - Linkages include community-based services, housing/landlord, health/behavioral health, financial, legal, social, employment etc as well as social support and fun
 - A “referral” does not equal a “meaningful linkage”
 - CMs need to engage with the resources with the tenants throughout their stay in PSH
 - Regular check-ins
 - Agencies may need to develop higher-level connections through MOU’s
 - Tenant Resource Guide



Discussion group:

What linkages have been most successful?
What linkages are most difficult for tenants
to connect with?

Changing Expectations



Moving from crisis to planning

- May start with immediate to 15 minutes from now

Critical thinking

- Using strategies and resources that work best for Veteran

Structure and purpose

- Developing a structure and purpose to days

Developing new or changed life

- From homeless to tenant, family member, student, worker, advocate, artist, peer, mentor

Closing

Service Planning is a part of a process that includes engagement, assessment, goal setting and planning

The connection of client goals and experiences to the planning is key

The connection of the plan to the work allows for clients to take the lessons learned and apply them

The goal is to develop a predictable and person-centered process that can provide guidance for the work

How will you use this in your programs?

***Meet people
where they are,
but don't leave
them where they
are.***



Additional Information & Resources

Resources for Tenancy Education



Tenant Rights by State

<https://www.jud.ct.gov/publications/hm031.pdf>

RentWise Workbook: University of Nebraska

<https://digitalcommons.unl.edu/cgi/viewcontent.cgi?article=4473&context=extensionhist>

Harm Reduction Plan to Prevent Eviction – Example

Housing Risk	Options	Factors in favor	Factors against	Non-negotiable
<p>Eviction:</p> <p>Tenant is yelling at night. You suspect this is about psychosis. The neighbors are complaining, and the landlord has complained</p>	<p>Focus on the behavior, explain the problem to the tenant and look for solutions</p>	<ul style="list-style-type: none"> • Tenant feels in control 	<ul style="list-style-type: none"> • Tenant denies the behavior and says they are being bothered at night. 	<ul style="list-style-type: none"> • Landlord: Must address the nuisance behavior • Tenant: must see the threat as real
	<p>Options to feel safer in the unit</p> <p>Such as extra locks, music or other noise, carpets, drapes etc</p>	<ul style="list-style-type: none"> • May address noise complaints • Allows tenant to remain in unit 	<ul style="list-style-type: none"> • Expensive • Treating a problem the tenant denies 	<ul style="list-style-type: none"> • Landlord: all tenants must have quiet enjoyment • Tenant must not feel targeted
	<p>Assistance form PCD, perhaps sleep medication</p>	<ul style="list-style-type: none"> • May resolve nuisance • Tenant is uncomfortable not sleeping. 	<ul style="list-style-type: none"> • Won't see psychiatrist • Difficult to negotiate for sleep medication 	<ul style="list-style-type: none"> • LL: Must address nuisance • Tenant does want relief

Warm Handoffs



‘Warm’ handoffs are recommended

- Meeting between the worker and Case Management staff or the staff for any on-going service with each tenant
- Build bridge between workers and the participant, transfer engagement
- Review rights and responsibilities for each resource
- Share info on what each person is looking for from the service
- Review Case Manager’s role and review service/ program's role and tasks.
- May set up regular meetings to discuss the collaboration is many referrals into the program