Providing Services in Permanent Supportive Housing Connecticut, 2025

Agenda

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

Introductions

- Please introduce yourselves by Project

- Brenda Earle – DMHAS
- Liz Isaacs – HI
- Phylicia Adams – CSH
- Andrea White – HI

- Think of something you are looking forward to doing this Spring

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.
- There is a structure to PSH which prepares each tenant to live more independently in the community

Organizing Principles: Housing First

Housing is recognized as the base.

- 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*

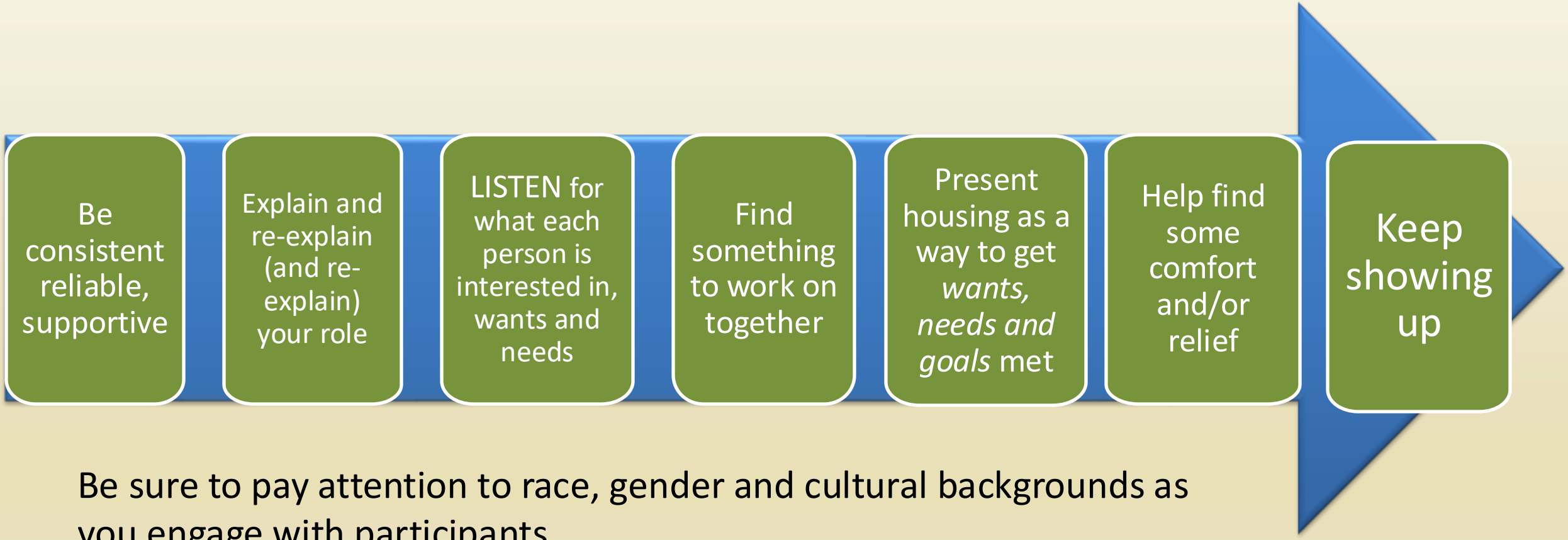
1. Safety
2. Trustworthiness and Transparency
3. Peer Support
4. Collaboration and Mutuality
5. Empowerment, Voice and Choice
6. Cultural, Historical, Racial and Gender Issues

*Adapted from SAMHSA Trauma Informed Care

Separation of Roles: Property and Services

- The function of Property and services are separate
- 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 serves 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 stive for
  - 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?

Persistent Engagement Exercise

Think of someone who is not engaging

- They may be passively not engaging, aggressively not engaging, or a combo

What do they do during a normal day?

- Are there times when things are calm, or the person seems to be enjoying an activity?

What have you tried to connect with them during those moments?

What behaviors / skills are you rewarding through time and attention?

- This could just be you are happy to see them

How will this connection and knowledge help you in times of strife or in moving things forward?

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

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

Assessment

- Assessments must be completed at least annually; 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

Service Planning

- Limit the areas of intervention – no more than 3 goals
- Focus on the most pressing needs that impact housing
- Relate all interventions to tenants' long-term goals
- Be aware this may not be a linear process
- Be mindful about moving from crisis

Focus Areas for Phase Plan

Focus on connecting people to support and services for greater self sufficiency

- Goals setting by each person in partnership with the worker
- Connection to high quality sustainable services and supports
- Shared-Decision Making and Harm Reduction approach
- Use success on service plan goals to build confidence for making other changes

Focus on long-term stability

- Use person's goals and housing stability focus
- Help assume role and meet expectations of tenancy and community
- Teach rather than do, mentor each person to work with services in the future

Strong expectation that each person becomes part of their community

- Work on structure purpose and activity
- Transition and recovery of valued life roles
- Afternoon session on service planning

Service Plans

CTI Phase Plan for Housing Stabilization

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?

Opportunity to move on

- Moving on from PSH is something that many people want
- The possibility of moving on helps tenants develop equity in their current housing and ties using resources and lease compliance to moving towards goals.
- Moving on also offers a context to problem solve issues as they come up
- It is important to develop criteria to move on, the resources necessary and cover both moving on with increased independence and moving on with increased support.

Crisis

Sometimes even with the prevention techniques, relationship, planning, de-escalation and program structure crisis does escalate

There are many things we can not control

We want to be aware of resources available to us in this situation and what to do in the time it takes to access these resources, what support we have immediately

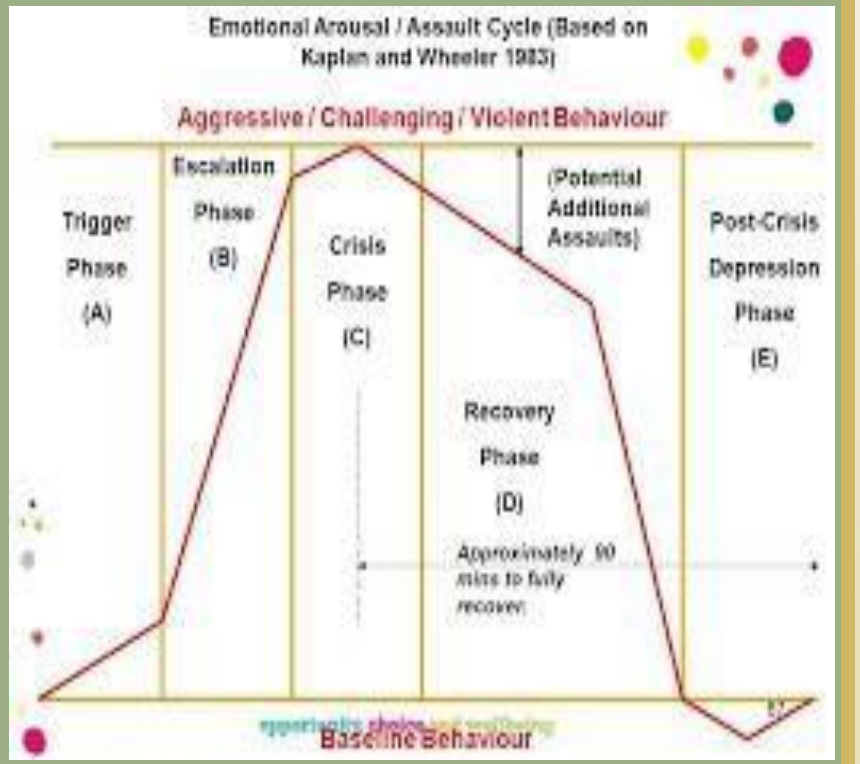
Planning is key with your colleagues, your supervisor and the senior staff in the program. Programs should have policies and procedures about dealing with crisis - both what to do and how to get help

Finally, it is important to understand the physiology of a crisis response to guide our interactions

Look at the Crisis recording and home visit recording for more crisis and staff safety tips

[Crisis Discussion]

The assault cycle



How people progress through crisis

- When and how to intervene depends on assessment skills
- Early, we can use the de-escalation techniques. As the diagram shows people may be triggered and we need to prepare to respond.
- As people escalate, they are flooded with adrenalin and de-escalation becomes a containment strategy
- Try to remove the person from the conflict or refocus. Be aware adrenalin is still high.
- We do not want to ask the person to talk about the incident or be reintroduced to the conflict until in post-crisis phase. It will re-escalate quickly.
- The time to debrief or mediate is after the adrenalin has dissipated (approximately 90 minutes).
- If we can not limit the person's access, remove everyone else from the scene.

Getting Help

- Have a discussion in the team about when to call for help.
- Know who to call: mobile crisis, your supervisor, the police or ambulance, take person to a walk-in clinic (with someone else)
- Is the person at risk to themselves or others, is the person making threats, does the person not responding to attempts to de-escalate and remain in the situation?
- Do you have the resources to remove the person from the situation in order to give them a chance to calm down?
- Do you feel like the situation is escalating or that the situation is getting out of control?
- What help is available to you within the program, what outside resources can you call on?
- What is their response time? What is the plan until they arrive?

Coordinating with Community Partners

Crisis Prevention includes meeting basic needs and engagement

Look for a relationship with the last services they engaged with get information about what has been helpful, what education was provided, can they transfer some of the trust and engagement

Meet basic needs: do you need assistance from other agencies to increase income and access housing?

What about issues with mental or physical health what do you need in order to help people stabilize and prevent crisis, what do you need to address crisis when it occurs?

What about housing what relationships do you need in order to prevent crisis, what about when there is a crisis where do you need assistance?

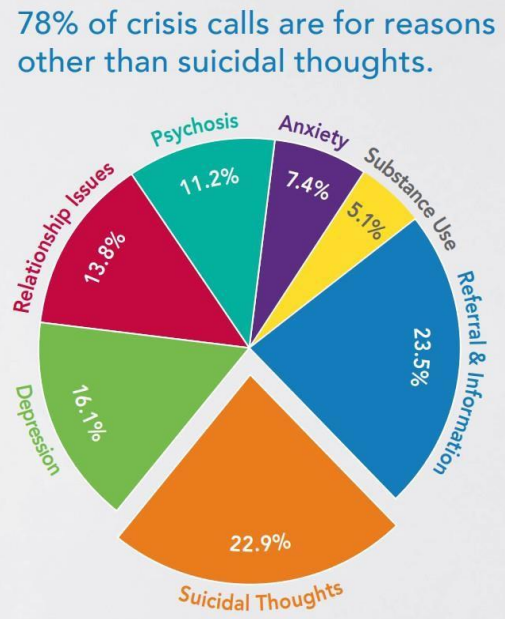
Working with Clinical Services

Clinical Consultation: using services or internal program resources to case conference and plan regarding people that may be at risk has been helpful to avoid a crisis situation

Some programs have nurses available from a medical clinic or internally to case conference and plan around medical issues

Connecticut has mobile crisis services that may accompany the police on mental health calls, CIT officers in the police department and the Crisis Teas and walk in clinics that provide information & referrals, the suicide prevention hotline, in-person assessments, crisis services.

Working with Mobile Crisis



As with any program you want to meet with them and ensure that the issues that are coming up in your program are eligible for their services

What can you expect in terms of the initial visit and follow up What is

the time frame once the referral is done?

- This is many cases will decide how you use this service

When is it better to call the police, is it possible to request at CIT officer (trained in working with mentally ill people)

You have licensed clinicians available in your agency who can apply for transport to an ER? DDMHAS

How will the follow up with the hospital be handled

https://portal.ct.gov/dmhas/cmhc/services/cmhc-mobile-crisis-intervention-and-evaluation

https://www.ctbos.org/wp-content/uploads/Mental-Health-Resources-.pdf

What about working with the Police/ EMS?

- When calling the police or EMS in a Crisis, look at your policies and procedures, be prepared to gather the info you will need. Note the call and if behavioral health ask for a trained CIT officer
- Ask staff to note the badge numbers of police and EMS staff
- You want to give all information that you have available, in a crisis situation you can usually share information such as medications
- Describe why you called in behavioral terms
- Calling the police or ambulance for someone overdosing is also protected

Debrief – After all is calm, talk it through

- Enlist your colleagues, supervisor or even the person's clinical services to talk through what happened, the response and get ideas for other things to try
- Give yourself time to process the incident
- Talk about what happened in a team meeting so everyone can learn from your experience
- Have a plan if things re-ignite
- In a calm moment talk it through with the person and get feedback.
  - Develop a crisis plan based on this experience

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 wthat are doing well.
- The afternoon session will go in depth on service planning and resource development.
- Lunch!

Service Planning Process
Permanent Supportive Housing
Connecticut, 2025

Introductions

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

Agenda

- Introduction to Session
- Expectations for Service Planning
- Getting to the Plan
- Sample Service Plans
- Resources
- Implementing in your program

Introduction

- The service plan guides the work with each individual PSH tenant
- 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 and address barriers in the future

Service Planning Process

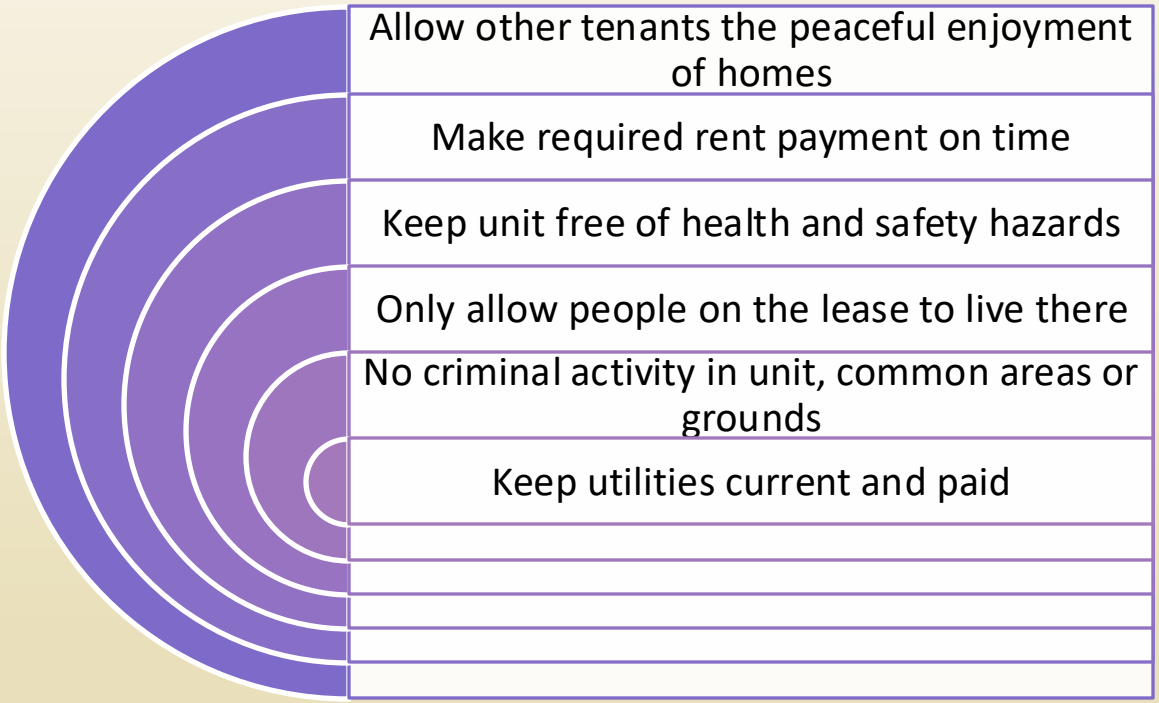
The Relationship

- Engage and establish a working relationship
- Identify what each person wants and what they are feeling
- Small goals are appropriate for the start
- As small things are achieved, confidence and trust grows
- Building motivation for a home and connecting it to the person's goals is the worker's focus during engagement

Assessment

- Assessment is a process not an event
- Allow the information to unfold over time
- As each person experiences challenges and progress the assessment will deepen
- Assessments are developed through observation, conversation, consultation and worker skills

Education: Obligations of a Lease/Tenancy



Rights of Tenancy

- Right to privacy – no entering apartment without permission or emergency
- Right to safe and well-maintained housing – repairs and safety considerations
- Right to due process – no eviction without proper process

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

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

Focused Service Planning

Limit the areas of intervention

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

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 Veterans 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.

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 was 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 tenants individual experience

Review Service Plans

Harm Reduction Plan to Prevent Eviction – Example

Housing Risk	Options	Factors in favor	Factors against	Non-negotiable
Eviction: Tenant is yelling at night. You suspect this is about psychosis. The neighbors are complaining, and the landlord has complained	Focus on the behavior, explain the problem to the tenant and look for solutions	• Tenant feels in control	• Tenant denies the behavior and says they are being bothered at night.	• Landlord: Must address the nuisance behavior • Tenant: must see the threat as real
	Options to feel safer in the unit Such as extra locks, music or other noise, carpets, drapes etc	• May address noise complaints • Allows tenant to remain in unit	• Expensive • Treating a problem the tenant denies	• Landlord: all tenants must have quiet enjoyment • Tenant must not feel targeted
	Assistance form PCD, perhaps sleep medication	• May resolve nuisance • Tenant is uncomfortable not sleeping.	• Won't see psychiatrist • Difficult to negotiate for sleep medication	• LL: Must address nuisance • Tenant does want relief

Connections to Resources

- Connecting tenants to community resources is a core practice in case management.
  - There has to be a life after case management
  - Establishing meaningful linkages that work and endure ends starts at the first interview and is offered throughout
  - Access to high quality clinical resources is core to the practice, the case manager helps tenants see the need for the services, assists with connections and teaching skills to manage the resources
  - It is not expected that all issues be resolved or all linkages made
  - We focus on behaviors that interfere with housing stability and resources to assist
  - Work to ensure that participants have the skills and resources to negotiate connecting to resources as they need them.

Connecting to Resources - 2

- 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

Connecting to Resources - 3

- Work to ensure tenants have the skills, tools and resources to manage ongoing meaningful engagement with resources
  - Assist in developing an Individual Resource List
  - Help them think critically about these resources
  - Raise awareness of the value of linkages to their goals and aspirations
  - Teach tenants to problem solve as issues come up and have confidence in their skills and resources to address the barriers.
  - Reinforce how linkages can address issues that interfere with their ability to maintain their base in the community
- Resources will often need to be adjusted as people move through the course of the PSH program

Discussion group:

What linkages have been most successful?

What linkages are most difficult for tenants to connect with?

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

Building Skills to Connect

- Educating on rights and responsibilities for each resource
- **Modeling** for each person to negotiate for services
- Trying it out and debrief
- Establishing regular check-ins to see if it is working
- Review cost and benefits – **critical thinking**
- **Recognizing** strong partners and good skills
- Renegotiate the relationship as necessary

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

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.

Resources for Tenancy Education

Tenant Rights by State

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

Rent Wise Workbook: University of Nebraska

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