Connecticut Statewide Street Outreach Standards

For projects serving people experiencing unsheltered homelessness funded by CT Department of Mental Health and Addiction Services, CT Department of Housing, CT Balance of State Continuum of Care

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Purpose

This document outlines standards for Street Outreach projects serving people experiencing unsheltered homelessness in the State of Connecticut. The standards align Street Outreach efforts across the state to support persons experiencing unsheltered homelessness in achieving permanent housing. These standards apply to all programs funded by the State of Connecticut's Department of Mental Health and Addiction Services (DMHAS), the State of Connecticut's Department of Housing (DOH) and the CT Balance of State Continuum of Care (CT BOS).

These standards 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) and the Connecticut Balance of State Continuum of Care (CT BOS) 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 standards combine compliance-oriented recommendations and essential practices for an effective street outreach program serving people experiencing unsheltered homelessness. Together, these serve as statewide standards for operating a Street Outreach (SO) project. For outreach staff, these standards and the appendices offer a concrete manual of effective street outreach practice.

The standards 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 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're an agency administrator, read **Section 4**.

Appendices offer resources for staff who are fulfilling one or more of the roles described in the standards. 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.

Values

- ✔ Our focus is on people experiencing unsheltered homelessness.
- ✔ We believe in Housing First. Everyone deserves safe and stable housing.
- ✔ We are allies in our clients' journeys toward 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 and kind with all clients.
- ✔ 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 and 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 Standards for Outreach Workers

Section 1

Outreach Practice Guidelines

DMHAS, DOH, and CT BOS funded Outreach projects are monitored on the standards in this section. Other outreach teams are encouraged to adopt these standards in their operations.

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 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 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.

- **Assessing client needs and developing housing and service plans.** Staff begin assessing client needs early on, and within 90 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.

- **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.

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.

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 and After First Contact

Before leaving the engagement:

- ☐ Did I get the person to talk to me?
- ☐ 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 ask about whether the person has a safe place to sleep at night?
- ☐ Did I document unsheltered homelessness in the participant's file? This should be done using CT HMIS if possible. If that's not possible then via a letter from the outreach worker describing the unsheltered circumstances. As a last resort, this can be a documented oral or written self-certification.
- ☐ Did I ask about whether they need an ID, Social Security Number or Social Security card?
- ☐ Did I ask the person about income?
- ☐ Did I ask about military service?
- ☐ 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 serious mental illness (SMI) or co-occurring SMI and substance use disorder?
  - ☐ See Presumptive PATH Eligibility Scan for concrete indicators

Within 24 hours of the engagement:

- ☐ Record the person and their location in HMIS (for all contacts)- Pre-enrollment contacts may be entered into HMIS or any database utilized by the CAN
  - As a reminder, Current Living Assessments should be completed in HMIS by outreach workers after every interaction.
- ☐ 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 serious mental illness or substance use disorder with a serious mental illness?

- ☐ 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?

Presumptive PATH Eligibility Scan

Homeless status

☐ Literally homeless

- People Living in a place not meant for human habitation (unsheltered) are the target population for street outreach projects.

Serious Mental Illness (SMI) or Co-occurring SMI & Substance Use Disorder

☐ PATH projects may only enroll participants suspected to have or diagnosed with a serious mental illness or co-occurring SMI & Substance Use Disorder

- 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. Also ask the person about current use and what their usage does for them (positives and negatives)
- A person may also be enrolled in PATH based on behavioral signs of SMI that seem to interfere with getting basic needs met:
- 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 and/or 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?
- Speech and thinking patterns seem off

☐ Diagnosed or suspected SMI must be documented in the case file – options include:

- Disabling Condition Verification that specifies an SMI;
- A standard mental health screening instrument that suggests that the client should be referred for further assessment for SMI. (e.g.. the Modified Mini Screen); or
- Case notes that document observation by an outreach worker of possible mental health symptoms and/or collateral information from another service provider

☐ When SMI is suspected but not yet verified, the client should be referred for further assessment.

Respect Clients' 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
- CoC funded projects only:
  Provide outreach participants with theses notices: Bill of Rights and Grievance Rights
  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. Even with a ROI in place, staff must protect client confidentiality, for example, by only sharing information on a need-to-know basis and using secure email whenever sending a client name or other confidential information.*

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 assisting in applying for benefits, including SSI/SSDI, Medicaid (also known as Husky Insurance), 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
- 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
- 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.*

- On an "as needed" basis, assisting clients to access a stabilization bed temporarily on the path toward permanent housing
- Document your housing-focused outreach by using case notes, current living assessments, and program enrollments in CT HMIS. Every interaction with a program participant should be documented.

Maintain a Client-Centered Approach

- 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—the outreach worker's role is to listen and negotiate with clients on how best to meet their needs.
- 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"
- 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
- Provide case advocacy on behalf of clients to make sure they receive needed services

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
- Intervene as necessary when someone presents an imminent risk of danger to self or others
- Help clients understand risks and reduce harm caused to themselves and others by risky behavior
- Help clients to establish a plan for how they will reduce safety risks while they remain unsheltered
- 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

Conduct Needs Assessments 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 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.
- Outreach workers are also responsible for documenting the homelessness of people they work with. The best way to do this is by enrolling all households you are consistently working with in a CT HMIS program. As a reminder, all outreach workers should complete Current Living Assessments at every interaction, to document the specific living situation of all households you are supporting.

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:*

- *Social Security Number and/or SSN Card application*
- *State ID*
- *SNAP/Food Stamps application*
- *SSI application, noting that not all households require a SOAR application. SOAR is best utilized for instances where a participant's mental health makes it especially difficult to collect documents. For many people, the standard SSI application process may be sufficient. Get some tips from the SOAR team about how you can support a non-SOAR application.*

- *Employment*
- *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

- 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 day, 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*

- 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

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 at the program where the client will get ongoing services 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, CAN priority lists, Public Housing Authority 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?
- ☐ Do I have at least 2 unexpired doses of medication to reverse an overdose (naloxone, also known as Narcan)?
- ☐ 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 the contingency plan for worst-case scenarios or dangerous situations? If not, review
- ☐ Know your backup plan. How close will your outreach partner be? How long will it take for the police, ambulance, or a crisis team to get there? Plan any interventions accordingly.

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 person experiencing homelessness you know.
- ☐ Always do outreach with a partner or 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.
- ☐ 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 your 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.

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

De-Escalation Methods

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 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

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

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 Standards

Section 2

Supervisory Standards

DMHAS, DOH and CT BOS funded outreach projects are monitored on the standards below. Other outreach teams are encouraged to adopt these standards in their operations.

Projects should have supervisory capacity to ensure their long-term sustainability, decrease staff turnover, and facilitate clients exiting homelessness to permanent housing. Projects should 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 Standards

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)
- 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, always pairing staff, 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, and other resources 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 Checklists

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 do they have 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 Hub and CAN referrals
  - ☐ Collecting and sharing all eligibility documentation for enrolled clients
  - ☐ Collecting and entering CAN required data elements into HMIS

- ☐ 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?
- ☐ What meetings are staff attending? Any we can remove?
- ☐ Any outstanding CAN 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 the 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 data 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-training 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 Standards for Program Manager

Section 3

Outreach Project Standards for Program Manager

DMHAS, DOH and CT BOS funded outreach projects are monitored on the standards below. Other outreach teams are encouraged to adopt these standards 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 unsheltered homelessness. 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, DMHAS, and CT BOS 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, syringe exchanges, police departments, and other municipal departments, Street Outreach projects work to identify and engage people living unsheltered 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.

- 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.

- 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

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.

Outreach Planning: Creating and Maintaining the Outreach Plan

Street outreach projects receiving funding from DMHAS, DOH, and CT BOS (including subrecipients) 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. 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
  - Frequency of engagement of the most vulnerable clients;
  - Expected volume of 211 & CAN referrals and outreach response approach and timeframe;
  - Frequency of engagement of the most vulnerable clients;
  - Expected volume of 211 & 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 across outreach teams for participants eligible for enrollment in multiple types of 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 subrecipients are involve

Canvassing When/Where:

- ☐ Includes street outreach efforts to locate and engage people experiencing unsheltered homelessness 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 AND provide housing focused case management services
- ☐ 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
- ☐ Respond to public concerns regarding unsheltered people

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 standards below to ensure a robust, accurate data environment:

- Record participant locations using the Current Living Assessment (HMIS Data Element 4.12). This ensures that clients can be located when the primary worker is unavailable and enables other community partners to also 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
- 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 & 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

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] Serious mental illness or suspected SMI 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.)

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.

- Each participant has a needs assessment and service plan that:
  - Follows the Assessment & Service Plan template
  - Was created within 90 days of project enrollment
  - Is updated at least every 90 days
  - Is signed by the participant, outreach worker and supervisor
  - Includes specific and measurable goals (service plans)
  - Includes action steps, who is responsible, and timeline to complete (service plans)
  - See sample of a completed Assessment and Service Plan

- Participants are discharged from the project only for permitted reason

- Participants are connected to appropriate on-going services in advance of planned discharge

Safety Protocols

Project maintains safety protocols for frontline staff that include standards 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.

- Pairing staff 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 detail

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.

Standards for Agencies Receiving Street Outreach Funding

Section 4

Standards for Agencies Receiving Street Outreach Funding

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

Agencies, whether direct or subcontracted recipients of DOH, DMHAS or CT BOS 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 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
  - Agencies receiving CoC funding must have: an anti-discrimination policy that outlines policies to ensure affirming care for LGBTQIA+ participants and a plan to ensure meaningful access to services for people with limited English proficiency.
  - Procedures to mitigate any conflicts of interest that are present
- Address conflicts of interest, including
  - Policies requiring staff and Board members to disclose conflicts of interest and prohibit financial interest or benefit from the 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
- 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, & that they are connected to educational services to help them succeed in school

- Establish 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

- Agencies receiving CoC funding must also have: an organizational chart illustrating lines of authority, and written job descriptions defining staff duties

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 – agencies receiving CoC funding are required to have at least one such person

- 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*** for more information.

Agency standards 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 Standards***

- 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 standards 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, short-term housing to supplement current emergency shelter and transitional housing options.

- 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*

- *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.*

- *Protocols and expectations for training outreach staff to follow the plan*

Suggested Training Topics for Agency Staff

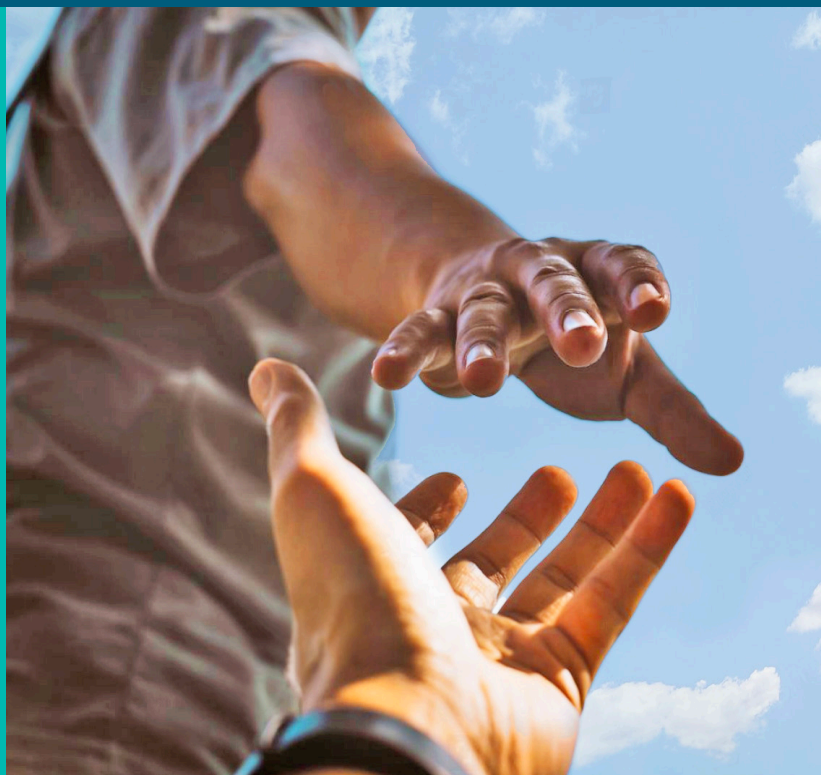
Agencies are responsible for ensuring that all staff participate annually in at least 12 hours of training on topics that will help them improve their street outreach service provision for people experiencing unsheltered homelessness.

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
- Mental Health 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 withdrawal management (detox) beds, contacting mobile crisis, 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 & addiction
- Coordinated Access Network (CAN) structure, policies, assessments, by-name lists and referral process
- Coordinated Access Network and HMIS data entry

Appendix



Appendix A: Outreach Plan Template

CAN:	
AGENCIES PROVIDING STREET OUTREACH:	
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: TUESDAYS	*1pm – 3pm*	*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 outreach 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*

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) 555-1111 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, Wednesdays & 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)

SYSTEMS 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)

EMERGENCY PLAN

Briefly describe steps your project will take to help unsheltered people reduce risks during:

A) *Extreme cold weather/snow storms*

B) *Extreme hot weather*

C) *Flooding*

D) *Other emergencies*

A)

B)

C)

D)

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 REVIEW AND APPROVAL		
CAN Representative Name:	**CAN Representative Signature** (required 2x/year):	**Date:**
	PERIOD #1:	
	PERIOD #2:	
DMHAS Representative Name:	**DMHAS Representative Signature** (required 2x/year):	**Date:**
	PERIOD #1:	
	PERIOD #2:	

Appendix B: CT Street Outreach Assessment and Service Plan Template

Instructions:

- All street outreach projects are required to complete an assessment of client service needs and an initial service plan **within 90 days of participant enrollment**.
  For Path projects only:
  - *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 90 days.
- 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.
- This template meets these requirements. All street outreach projects are required to follow this template. Projects may opt to use a different format, including an electronic format, as long as the content outlined in this template is included in that format.
- The template provides space for **up to** three goals. Participants should determine how many goals they choose to focus on.
  - 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 data required in HMIS.
  - Outreach staff should review the information in HMIS 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.

Assessment and Service Plan Template			
Part 1: Assessment			
Participant Name:			
Plan Start Date:		**Plan End Date:**	
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)			

Strengths and Supports Summary	
Income and Financial:	**Mental Health and Substance Use:**
Employment:	**Family and Supports:**
Housing:	**Skills:**
Health:	**Education:**
Other:	
What strengths/supports will be most helpful in the housing access and stabilization process?	

Part 1: Assessment (Cont) - Barriers Summary *(check all that apply)*

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

Debts/Expenses
- ☐ 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
- ☐ Serious mental illness
- ☐ Substance use disorder
- ☐ Health or mental health crisis, detox or hospitalization in the past year
- ☐ Multiple hospitalizations in past year. #: ___
- ☐ 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: _____)

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 and Barriers**
1	
2	
3	

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 and Friends ☐ Life Skills					
Goal 2:					
Check Area: ☐ Housing Stability ☐ Financial ☐ Health/Mental Health ☐ Substance Use ☐ Family and Friends ☐ Life Skills					
Goal 3:					
Check Area: ☐ Housing Stability ☐ Financial ☐ Health/Mental Health ☐ Substance Use ☐ Family and Friends ☐ Life Skills					

Particpant Signature:		Date:	
Staff Signature:		Date:	
Supervisor Signature:		Date:	

Appendix C: Requirements for CT BOS CoC Funding Projects

Street Outreach projects funded through the Connecticut Balance of State (CT BOS) Continuum of Care are required to follow all relevant requirements established by:

- the U.S. Department of Housing and Urban Development (HUD)
- the CT Department of Mental Health and Addiction Services (DMHAS)
- the Connecticut Balance of State (CT BOS) Continuum of Care