Research Report

Dimensions of Promising Practice for Street Outreach Supports in Ending Homelessness

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Calgary Homeless Foundation
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Introduction

“I always found reintegration to be a funny word because these people have never been integrated to begin with” – Outreach worker #1

“Rough sleeping” homeless individuals are those living and sleeping outdoors or in public spaces not intended for human habitation. These individuals represent a particularly vulnerable segment of the homeless population, with a range of significant support needs and limited engagement in existing community services. Street outreach work involves the identification and engagement of rough sleepers, with the aim of facilitating shelter access, service utilization, and long-term stability and well-being.

A great deal of existing literature has examined outreach practices amongst homeless individuals describing and evaluating specific outreach programs, identifying common themes, articulating the perspectives of rough sleepers utilizing outreach services and or examining particular components of the outreach process (such as engagement or assessment). However, little if any existing literature integrates these various perspectives on outreach practices, in conjunction with best practices from the perspectives of outreach workers and people with lived experience towards development of standardized practice for this work.

The purpose of this project is to address this gap in order to illustrate ‘dimensions of promising practice’ when engaging in street outreach work, specifically to end homelessness.
Background

From March 2010 through September 2011, the Calgary Homeless Foundation (CHF) led a collaborative research project to identify and articulate promising practices for engaging in effective street outreach work. The goal was to develop standards of practice for outreach workers who work with Calgary’s most vulnerable homeless people, rough sleepers. This project occurred in two phases: a literature review and interviews with local outreach workers and rough sleepers.

The literature was synthesized to articulate a definition of outreach, key activities, processes and principles of effective outreach. In addition, eight outreach workers, 13 men and one woman who were sleeping rough at the time of the research were interviewed. Information from these interviews complimented and localized the literature as well as articulated primary challenges and promising practices.

There is a strong relationship between outreach and case management, particularly in Housing First. In 2010, the CHF launched Standards of Practice for Case Management. This project specific to outreach work is designed to align and compliment these standards.

This report includes a descriptive analysis of rough sleepers, their unique needs and wants in relation to service provision, the relationship between rough sleeping and outreach, individual and systems barriers to accessing services, promising practices for effectively engaging rough sleepers in to supports, and promising practices for transitioning the client relationship from the outreach worker to the case manager.
Section 1: Rough Sleeping

Defining Rough Sleeping

“Street homelessness” or “rough sleeping” individuals are generally considered to be those homeless individuals who sleep in the open air (on the streets, in parks, in doorways, under bridges, etc.) or in places not meant for human habitation (such as bus and subway stations, in barns or sheds, in abandoned buildings, etc.), as opposed to sheltered homeless individuals who are typically defined as those who usually sleep in public and/or private shelters (Homeless Link, 2008; Kryda & Compton, 2009; Larsen et al., 2004).

Understanding Rough Sleeping

Hodgetts et al. (2007) examined the impacts of homelessness as experienced by 12 rough sleepers in London. Participants reported unhealthy, and cold physical living conditions which could lead to serious illness and concerns related to hygiene. Material hardships were exacerbated by perceived social stigma. They also experienced risks associated with existing ailments, safety issues, the need for constant vigilance and readiness to defend oneself, and stress related to hardship and coping. Participants reported feeling out of place, distrusted and disrespected. All participants described alcohol or drug use as a means of coping with or escaping from the realities of their homeless experiences and feelings of exclusion. However, alcohol consumption was also linked to a sense of marginalization, and feeling out of place and with increased susceptibility to illness. Participants in the Calgary study reported similar living conditions, health concerns and feelings of isolation and indignity. One rough sleeper who had received bars from two major shelters expressed:

“being out here, it’s cold, it’s wet and miserable. Seeing everyone walk by me and they have a home to live in and I don’t…being outside is draining to me right now. There are times I want to break down in tears but I can’t, I go into my bag and grab my beers and it’s been my escape I guess”.

Rough sleepers who participated in the project spoke to the psychological effects of the stigma attributed to them as a result of their condition of homelessness. The feelings of shame and consequently helplessness they felt to try and conceal their status as “homeless” led some to further isolate themselves from the larger community. One man spends his days walking in back alleys, reasoning he attempts to remain invisible as he is embarrassed at the way he looks and that in order to survive he must pick in the dumpsters.

Previous studies of individuals sleeping rough in Canada and the United Kingdom have explored certain demographic characteristics of this sub-population of the homeless. According to these studies, between 70% and 89% of rough sleepers are male, between 18% and 30% are female, and roughly one percent are transgendered (Cebulla et al, 2009; City of Toronto, 2009; Farrell et al., 2002; Fountain et al., 2002; Goldberg et al., 2005). Approximately 60% to 80% of rough sleepers are aged 25 to 55, with a small proportion of people under the age of 19 or over the age of 55 (City of Toronto, 2009; Farrell et al., 2002; Fountain et al., 2002; Goldberg et al., 2005). In Calgary’s most recent point-in-time count, which occurred on a bitterly cold night, 65% were male and 35% were female. As well, 89% were between the ages of 25 and 64 (Calgary Homeless Foundation, 2012).
In Canada (Toronto and Vancouver), between 25% and 34% of individuals sleeping rough are of Aboriginal heritage (City of Toronto, 2009; City of Vancouver, 2005; Goldberg et al., 2005; Graves & Davidson, 2001). Typically, Aboriginal individuals are disproportionately represented among individuals sleeping rough in Canadian cities, when compared to the broader local population (City of Vancouver, 2005; Graves & Davidson, 2001). This imbalance was affirmed by Goldberg et al. (2005) who found that in Vancouver, individuals of Aboriginal background account for 34% of the total street homeless population (compared to 23% of the total sheltered homeless population and 2% of the total regional population). The overrepresentation of Aboriginal is further affirmed in Calgary where Aboriginal people make up 2.5% of the total population, 16% of the homeless population and 38% of rough sleepers (Calgary Homeless Foundation, 2012).

This suggests that homeless Aboriginal individuals may avoid shelters that do not appropriately serve Aboriginal people (Goldberg et al., 2005). Of the 13 men that were interviewed, ten were Aboriginal. While the personal stories they shared of their pathways into homelessness varied, what was in common were histories of trauma and abuse. Four of the ten Aboriginal men had grown up in foster homes of white families, all had reported substance abuse, and Aboriginal participants reported a greater duration of rough sleeping of up to 25 years. One Aboriginal man ascribes his condition of homelessness and involvement with the criminal justice system to his early childhood experiences, “because I’ve had so much shit happen to me when I was a kid, I don’t care about being an adult. I fight every day; I knock people out all the time. I like it [sleeping outside] because I can do whatever I want. There’s a devil in my head and I just do what I want to do”.

Extensive histories of trauma and abuse among the Aboriginal population, grounded in the Canadian colonial legacy and resultant intergenerational trauma highlight the need for Aboriginal specific interventions and approaches to working with Aboriginal rough sleepers.

In 2011, the University of Calgary in partnership with the Aboriginal Friendship Centre of Calgary, examined services across Western Canada to identify best practices for working with Aboriginal people experiencing homelessness. Seven components of best practice were identified and are applicable to outreach. They are:

1. Cultural safety is foundational for all organizations and staff to provide respectful and appropriate services for Aboriginal people.

2. Partnership and relationship building is critical in fostering a collaborative process to address the many needs of Aboriginal homeless peoples and create cultural safety.

3. Aboriginal governance and coordination of homeless services needs to be supported.

4. Adequate and equitable funding is required for Aboriginal specific services.

5. Research and evaluation is required to better understand best practices for Aboriginal homelessness.

6. Increased number of Aboriginal staff working with the homeless population.

7. Cultural reconnection is the cornerstone of addressing the needs of Aboriginal Homeless peoples (Thurston, W.E., Oelke, N.D., Turner, D., & Bird, C. 2011).
How Prolific is the Issue?

Street enumeration of people experiencing homelessness, typically underestimates the number of individuals sleeping rough because of the difficulty in finding those who do not use services or who do not spend time where homeless individuals typically congregate (Goldberg et al., 2005). The most difficult group of homeless individuals to accurately understand and enumerate are those sleeping rough (Larsen et al., 2004). In addition, certain populations of rough sleepers – particularly young people, women, and members of minority ethnic groups often remain hidden and their numbers are under-recorded (Randall & Brown, 2002).

Rough sleeping estimates reported in most studies are based on single night counts; however, numbers can fluctuate depending on the timing of a count. Point in time counts (e.g., counts carried out over a single night) will report lower numbers when compared to ‘period counts’ (e.g., counts carried out over a period of time). The time of year can also influence count results. For example, fewer people will be identified outside during cold winter weather (Farrell et al., 2002).

The average number of rough sleepers or the percentage of the total population varies across studies. Larsen et al. (2004), estimates that roughly one-third of the total number of homeless individuals in any given city are sleeping rough and not using the emergency shelters or transitional housing facilities. According to Randall and Brown (2002, 2006b), the number of rough sleepers recorded on single night counts represent roughly one-tenth of the number of people sleeping rough over a one-year period. As Farrell et al. (2002) explain, simply counting the number of homeless individuals living on the street, without attempting to understand their experiences or service needs results in an incomplete and potentially non-useful portrait of the population. Similarly, Randall and Brown (2006b) claim that while single night street counts can measure basic trends, it is equally important to assess the numbers of individuals sleeping rough over a period of time while also attempting to identify and understand their changing support needs.

Farrell et al. (2002) identify two sub-groups of homeless individuals not using shelters, defined according to their length of homelessness. The first group includes individuals who are recently homeless and not currently aware of, or connected to, shelters and services. For these individuals, immediate psychosocial and housing supports and assistance in accessing services are of central importance to prevent continued experiences of rough sleeping. The second group includes individuals who experience chronic homelessness and who perceive barriers to shelter access or prefer accommodation outside the shelter system. These individuals may require more intensive assistance and supports to access accommodation and prevent continued rough sleeping.

Sleeping Rough Instead of in Shelters

There are a myriad of reasons that people sleep rough as opposed to using shelters, some related to personal choice and others due to enforced bans or eligibility restrictions. In a 2009 study in London, UK, 21% of rough sleepers in the study had been evicted from shelters, and 22% had chosen to leave shelters. Alcohol, drug, and mental health support needs were associated with increased risk of shelter eviction (Cebulla et al., 2009).

An American study by Kryda and Compton (2009) examined rough sleeper perceptions of shelters. Many participants reported that shelters were unsafe, due to the prevalence of violence, theft, drugs, and the unsanitary conditions including lice and rats. The presence of drugs in shelters was reported
as a challenge for some individuals attempting to recover from substance use. Many participants reported shelters are not viable short-term solutions, preferring the streets to the problems they had experienced at shelters.

Other reported factors for opting not to access shelters include:

- a lack of shelter facilities able to accommodate youth, older adult individuals working shifts, individuals with pets, individuals using alcohol or drugs, addressing the specific needs of individuals who are transgendered, have medical needs or developmental disabilities, and those of diverse cultural backgrounds, including Aboriginal individuals
- a dislike of, or conflict with other shelter residents
- rules of shelter use or shelter eligibility criteria (e.g., sobriety or bans on drug use)
- a lack of permanent (year-round) beds in emergency shelters and safe houses to accommodate individuals who are homeless
- a lack of timely referrals into housing and support services (e.g. de-tox, treatment facilities)
- a lack of adequate affordable housing (Cebulla et al., 2009; City of Vancouver, 2005; Larsen et al., 2004; Randall & Brown, 2002, 2006a, 2006b).

In a study of 29 former rough sleepers in London, Randall and Brown (2002) report that approximately 50% of participants had at some point in the past, preferred to sleep rough rather than access shelters. Participants referred to the companionship they found among other rough sleepers, particularly if they had past experiences of trauma. Certainly, feelings of security and safety associated with staying with friends were identified as reasons for returning to the streets. Some participants reported on the streets, it was easy to access services that helped to sustain the rough sleeping lifestyle such as acquiring food or clothing. Only 25% of participants believed that anything would have helped them avoid subsequent experiences of rough sleeping. They blamed themselves for not addressing their substance abuse issues or for a lack of motivation in finding helpful services.

Interviewees from Calgary’s research identified additional reasons for avoiding Calgary shelters as:

- perceived risk of infection or illness due to unsanitary and overcrowded conditions
- strict rules, line ups and wait times for services, and often negative and discriminatory attitudes of staff – particularly among the Aboriginal respondents
- previous bad experiences - including receiving a ban from entering a shelter, denial of services, and feeling let down or abandoned in their efforts to end their homelessness
- they felt they had more freedom outside

A few of the interviewees conveyed the threat planning ones pathway out of homelessness can impose, the damage that can ensue from putting your trust into an agency or staff to work towards some sort of change in your life and then have it fall down around you. One participant who expressed such frustration bitterly says,

“What’s the point? You talk about stuff you can’t get done, that’s not happening and it’s very frustrating and in the meantime you still have to live your life and a lot of people don’t even bother with it because it’s much to handle. To talk about a new life but not being able to have it”.
This sentiment denotes the importance of continued engagement and open, trusting relationships between outreach workers and clients. Ample research demonstrates that rough sleepers are disengaged from service providers precisely because they do not have faith in their ability to provide assistance. Outreach workers are the primary means by which to begin to rectify the relationship between rough sleepers and systems.

Barriers to Accessing Services

Rough sleepers are less likely than other homeless individuals to access services including supports for substance use and mental health treatment. The lack of service utilization may be due to individual reasons or institutional barriers, both actual and perceived. Thompson et al. (2006) explored barriers to access, including rigid or unrealistic eligibility criteria such as required attendance at religious services and extremely long wait times to access laundry and shower facilities. The practice of having to “jump through hoops” and fill out extensive paperwork also discouraged service use. Participants also reported that service providers were often disrespectful, rude, or condescending and they were treated as less mature and intelligent than they actually were; reporting that their autonomy and independence were disregarded.

Fountain et al. (2002) examined service access barriers among 389 rough sleepers in London. The primary barriers to service use identified by participants included violence, substance use and chaos at shelters, and a lack of knowledge concerning where to find services. Thirty-nine per cent of participants reported being excluded from one or more service types in the preceding year. The primary reasons for exclusion were physical violence toward other clients, and drug and alcohol use. Forty-two per cent of participants who were dependent on drugs or alcohol had been excluded from services.

In a study by Social Data Research (2005), interviews were carried out with 17 Aboriginal clients accessing Aboriginal and mainstream services in Ottawa. When asked why they did not utilize certain service agencies, participants identified personal reasons: conflicts with other clients, evictions due to fighting, cultural differences with other clients, location-related reasons: services too far away, as well a lack of awareness about agency services and shelter restrictions concerning alcohol use. Participants were also asked if there were any supports they currently needed but were not receiving, results were mostly related to a need for an affordable apartment of their own, perceived discrimination on the part of landlords due to their Aboriginal and homeless status, special diets that were not being met, waiting lists for drug treatment programs and transportation issues.

Cebulla et al. (2009) examined the experiences of rough sleepers who reported wanting to “go inside.” Many, however, also referred to the “freedom” of the streets in a positive fashion. This freedom may include a perceived lack of responsibility, bills, or need to address problems they are facing. In addition, individuals may be part of a community on the street and might feel pressure to remain outside and on the streets in order to maintain relationships. A number of participants described the addictive nature of the streets, and explained that they were “hooked” or “sucked in” by the streets. The communal nature of street life does pose unique challenges to working with the rough sleeper population when trying to achieve housing stability. Local outreach workers identified the immersion in street culture and the sense of attachment individuals exhibit towards their support networks on the streets can be a barrier to maintaining housing as individuals recently housed may
invite others to come and stay with them (putting their housing in jeopardy) or continue to reside on the streets to retain a sense of belonging and interaction.

McMurray-Avila (2001) reports that, according to outreach workers supporting homeless individuals with serious mental illnesses, it can take approximately nine months to engage certain outreach clients in basic services such as shelter, food, and health care programs. It can take another three to six months to encourage clients to obtain medication and benefits, and another nine to 12 months to achieve access to permanent housing (with ongoing case management support). The length of engagement process varies according to individual clients and other outside circumstances. The process may be more challenging – and slower – with individuals who are extremely isolated (as they may be easily threatened and have an exaggerated sense of personal space). Individuals who are more entrenched in rough sleeping may also require more time to engage with workers and develop a relationship (Homeless Link, 2008).

Individuals entrenched in rough sleeping and who may have grown accustomed to life outdoor, will require a great deal more support in both the engagement process by outreach workers and the follow up care provided by case managers. One Aboriginal man who has been sleeping outdoors for 25 years has recently been working with a local housing program says, “they’re going to try to take me off the streets, but to be honest I’ve become accustomed to the streets. It would be good to get up in the morning, go to the fridge and make a couple eggs and have a shower, but that’s the adjusting part. A big part of me says yes, but a part of me says no too…”

Vulnerabilities Specific to Rough Sleepers

Individuals who sleep rough as opposed to in emergency shelters have higher rates of chronic physical and mental health concerns. They are at greater risk of early death and more likely to experience co-currant disorders (O’Connell, 2005; Hwang, 2001).

Health and Mortality

Griffiths (2002) identifies a number of specific health issues typically exhibited among rough sleepers. These include physical health issues such as tuberculosis and hepatitis, poor mouth and foot health; respiratory problems; skin diseases; and infections. They may also deal with mental health issues such as schizophrenia, depression and personality disorders, and drug and alcohol dependency. Many rough sleepers experience a combination of these health issues.

Griffiths (2002), and Randall and Brown (2006b) report that the incidence of health problems is two to three times higher among individuals who sleep rough, when compared to the general population. Rough sleepers are also four times more likely to die from unnatural causes such as accidents, assaults, murder, drugs, or alcohol poisoning and 35 times more likely to commit suicide. The overall mortality rate among rough sleepers is estimated to be 3.8 to 5.6 times that of the general population.

“well I wasn’t supposed to live to 37, and I just turned 37, so if you really want to know I think I will just die” – rough sleeper who has been homeless 22 years.
A 2009 Calgary study of health issues amongst rough sleepers found that those who sleep outside are highly vulnerable to chronic and debilitating health issues including disabilities. In particular they found:

- 37% had a brain injury (disability)
- 30% had mobility issues (disability)
- 34% frostbite
- 22% asthma
- 22% Hep C
- 18% heart condition
- 14% liver disease
- 12% cancer
- 2% HIV/AIDS

Further, incidence of substance use and mental health concerns are higher for those on the streets. Specifically in Calgary: 94% of rough sleepers report substance use compared with 81% of those in shelters; 34% reported IV drug use compared with 28% in shelters and only 24% reported having accessed mental health supports compared with 34% of those in shelters (Calgary Homeless Foundation, 2009).

**Victimization**

In an American study, Lee and Schreck (2005) examine experiences of victimization among 2,401 homeless individuals. Forty-four per cent of participants reported having been victimized in some manner during their time on the streets with 50% having had money or belongings stolen from them, 21% having been physically attacked or assaulted and 11% of homeless women having been raped or sexually assaulted.

In a study of victimization amongst Calgary’s street youth, 75% reported being victims of violence while homeless, 20% of males and 33% of females reported having to engage in obligatory sex and 13% of males and 45% of females reported being forced into prostitution (Worthington et al 2009).

**Long Term Homelessness**

Rough sleepers are more likely to experience long-term homelessness (one year or more spent homeless) than those who access emergency shelters (Goldberg, 2005) and those who sleep rough over a long-term period accessed accommodation services rarely or only for short stays prior to returning to rough sleeping. Individual stays in accommodation services typically become shorter as they become more entrenched in rough sleeping. Cebulla et al. report that once individuals have been on the streets for more than two years, their chances of sustained exits from the streets are significantly reduced.

In Calgary, the average length of homelessness for emergency shelter users was 3.1 years and for rough sleepers was 6.9 years (Calgary Homeless Foundation, 2009). Participants in this study had durations of homelessness ranging from three years to 31 years with seven participants being chronically homeless for over 15 years.
Summary of Rough Sleeping

Differences between homeless individuals living in shelters and those living on the streets reflect a need for different intervention and service foci’s. While the street homeless represent a relatively small proportion of the total homeless population, they represent the greatest challenge with respect to engagement in services (Stergiopoulos et al., 2010) and incidence of chronic physical and mental health issues.

Despite significant support needs and challenges associated with service access and use amongst rough sleepers, many are open to working with service providers towards ending their homelessness. Street outreach can provide a means to identify and engage these individuals in needed services in order to facilitate desired changes. The significant vulnerabilities of rough sleepers and the difficulties associated with engagement in existing services illustrate the need for prioritized development and implementation of best practice interventions designed specifically to the needs including standards of practice for effective street outreach.
Section 2: Outreach

What is “Outreach”?

Morse (1987) provides a “process definition” of outreach, referring to “contact with any individual who would otherwise be ignored or un-served in non-traditional settings for the purposes of improving their mental health, health, social functioning or to increase their human service and resource utilization” (p. 9). Outreach workers actively approach potential clients on the streets and offer supports related to accommodation and services (Randall & Brown, 2006b).

Street outreach enables workers to respond directly and immediately to clients’ needs (Rowe et al., 1998), by bringing services to clients rather than waiting for individuals to come to services on their own (McMurray-Avila, 2001). Outreach services engage homeless individuals in locations they frequent, such as train stations, bus stops, streets, alleys, bridges and overpasses, parks, vacant lots, abandoned buildings and vehicles, wooded areas, riverbanks, and camps (McMurray-Avila, 2001; Ng & McQuiston, 2004).

Outreach is a harm reduction approach that aims to reduce the adverse effects of living outdoors. The primary goal of outreach when working with rough sleepers is to assist individuals into moving off the streets and into accommodation with supports (Broadway Homelessness and Support, n.d.; Homeless Link, 2008). This may be done by prioritizing those entrenched in rough sleeping and who exhibit most complex needs (BC Housing, 2010b). However, in order to reach these goals, focus should initially be placed on the prevention of harms associated with rough sleeping, including substance use, rather than focusing on the prevention of rough sleeping itself. As will be identified below, taking a harm reduction approach to outreach allows for the development of trusting relationships with clients, which then opens up space for appropriate intervention.

Erickson and Page (1999) view outreach as the initial and most critical step in connecting or reconnecting homeless individuals to health, mental health, recovery and housing services. Outreach and engagement are the first steps in connecting with street homeless individuals (Burt et al., 2004). Outreach activities are intended to assist individuals in engaging and maintaining engagement through services. They may focus on housing, but also link individuals to a wide range of services in an effort to maintain a more comprehensive view of their needs, acknowledging the importance of a holistic focus when supporting rough sleepers in their transition off the streets (Cameron et al., 2009).

Street outreach is an effective practice for reducing homelessness, by increasing the number of rough sleepers accessing services, and transitioning off the streets into permanent accommodation and meaningful activity such as education and employment.

An outreach project initiated by the Canadian Mental Health Association in British Columbia provided services to nearly 800 clients. Outreach workers assisted 34% of all clients to access housing. Two-thirds of these clients were housed in private rental units, and 78% were able to maintain this initial housing situation (City Spaces Consulting, 2007).

Stergiopoulos et al. (2010) describe a collaborative, inter-agency, multi-disciplinary outreach team in Toronto intended to facilitate housing access for individuals who are absolutely homeless, with a severe mental illness, personality disorder, developmental challenge or untreated medical needs. At
intake, roughly 84% of clients reported that they were living primarily on the street or in a shelter. Roughly 96% had spent more than 90 nights on the streets during the preceding six months. At the six-month follow-up, more than two-thirds of the clients were no longer living on the streets or in shelters, and 41% reported that they had spent fewer than 90 nights on the streets in the preceding six months.

Rowe et al. (2002) describe the New Haven ACCESS program, which provides outreach to homeless individuals with a mental illness. Over a five-year period, outreach and case management services were provided to more than 500 clients. As a result, clients reported fewer psychiatric symptoms, decreased drug and alcohol use, improved housing quality, increased income from public sources and improved quality of life at three and 12 months after baseline interviews.

**Outreach Programs**

Outreach workers are typically employed within programs that exclusively do outreach or within broader programs or agencies that support homeless individuals in a variety of ways. Successful outreach programs can be discussed in terms of client, agency and community successes. Successful outcomes often occur when effective outreach services are combined with case management (Christensen, 2009; Fisk & Frey, 2002; Power & Attenborough, 2003; Tsemberis et al., 2004; Erickson & Page, 1999; Rosenblum et al., 2002; Rowe et al., 2002; Lam & Rosenheck, 1999; Pollack et al., 2010; Hough & Rice, 2010; Measure Y Oakland, 2009; Greenberg et al., 1998; Tommasello et al., 1999; Slesnick et al, 2007; Stergiopoulos et al., 2010).

**Mobile Outreach**

Mobile outreach involves services move around and can be delivered in any location where homeless individuals might be found. Services may be provided from mobile clinics, vehicles, bicycle or on foot. Mobile outreach workers often offer material goods, practical services, harm reduction supplies and/or advice and information (Christian & Abrams, 2004; McMurray-Avila, 2001; Ng & McQuiston, 2004; NHCHC, 2002; Tommasello et al., 1999).

**Fixed-site Outreach**

Fixed-site outreach involves the establishment of outreach programs in or near shelters, and other service facilities, focusing on locations where homeless individuals already gather or go to seek assistance (Christian & Abrams, 2004; McMurray-Avila, 2001; Ng & McQuiston, 2004; NHCHC, 2002; Tommasello et al., 1999).

Fixed-site outreach may also be known as building-based outreach. As part of a building-based approach, workers may provide rough sleepers with referrals to accommodation and other supports. Providing outreach services in a building may enhance worker safety and ensure that resources such as on-line client databases and specialists are readily accessible. With building-based outreach services, potential clients can be certain of where and when to meet workers (Randall & Brown, 2006a).

**Blended Outreach**

Many outreach projects integrate fixed-site and mobile outreach approaches. For example, an agency might operate a fixed-site outreach program beside a shelter and send teams to conduct regular outreach on the streets. The two approaches are complementary. Individuals encountered
during street outreach may require more complex care than can be provided on the street or in a mobile unit, and can then be referred to better-equipped, fixed-site locations. Conversely, workers in fixed-site locations may experience challenges in locating clients for follow-up work which can be carried out by street outreach workers instead (McMurray-Avila, 2001; NHCHC, 2002).

**Processes of Outreach**

“They want the freedom to decide their own rules… so it’s kind of like their home and we need to be aware of that while saying you know hopefully we can provide something better for you than sleeping outside”. – Outreach Worker # 3

The processes of outreach or how outreach workers operate are different than the activities or what they will do.

Outreach services are often delivered in a phased approach for the worker to effectively engage rough sleepers into on-going conversations. Establishing trust and building a relationship is key to successfully engaging with rough sleepers. Because of this, processes are described as the phases of outreach.

The **pre-engagement phase** involves the identification and observation of potential clients, while respecting personal space and considering safety issues. Activities can include safety assessments, crisis response, verbal or non-verbal communication attempts and offering essential items focused on the development of trusting relationships.

The **engagement phase** involves empathetic communication and the learning of client ‘languages’. This phase also focuses on issues of trust. Accomplishments include the identification of needs and the reinforcement of client strengths, addressing basic/immediate needs, the introduction of roles, and the initial development of healthy boundaries, aiming to establish a working relationship. Local outreach workers emphasized the importance of honest communication and a commitment to the client.

“When you say you are going to show up you have to show up, when you offer something you have to be prepared to come through with that. Especially those who have had bad experiences with shelters or agencies, but once they see you are serious, they trust you and are more willing to talk about housing options” – Outreach worker #1.

The **formal relationship phase** is specific to beginning the formal activities of outreach while keeping client needs and wishes at the forefront. This may include the identification and examination of feelings of fear, guilt and anger, as well as joint assessments of goals, strengths and obstacles; the development of skills and supports; the enhancement of coping strategies and the mobilization of client strengths; the reinforcement of positive change; advocacy and referrals to identified services.

Once the relationship has been formalized, workers can support clients into conversations specific to housing and case managed supports. Both the outreach workers and the rough sleepers interviewed in Calgary expressed that the process is not linear and may take extended periods of time. It was also suggested that outreach workers stay in touch with clients once they had moved into housing and supports to aid in the facilitation of (re)integration and the development of social support networks within their new community.
Operating from a harm reduction philosophy will aid workers in successfully engaging clients in the above phases of outreach. This philosophy promotes the need to meet clients where they are at incrementally in order to develop a relationship grounded in trust. In this process, outreach workers non-judgmentally accept clients as they are and recognize the universality and interdependence of human rights (International Harm Reduction Association, 2010).

“When you are on the streets there’s no rules, nothing to enforce like in the shelters. So wherever the client is at, that’s where you have to be too…have to meet them where they are at, go at their pace, be flexible and adapt yourself to them”. – Outreach worker # 1

Successful **client outcomes** include:

- Transparent, honest, trusting relationships with outreach workers
- Consistent communication and access to outreach workers – willingness to meet with outreach workers
- Increase use of services including accessing shelter and basic needs services; or increased awareness of existing resources and how to access them
- Willingness to explore programs and services related to housing, substance use, or public benefits
- Access to timely and appropriate referrals to programming related to housing, substance use, health services or vocational skills
- Improved physical and mental health issues (e.g., mental illness treatment, HIV testing and use of harm reduction tools); or awareness of existing alignments or mental health concerns and willingness to address them
- Improved physical health status (e.g., number of health complaints, emergency room visits, reduction of psychiatric symptoms)
- Improved personal hygiene, self-care, and self esteem
- Improved emotional and task-oriented coping skills (e.g., coping with stressful situations)
- Reduced isolation and increased level of social support through service utilization
- Reduced violent, or criminal behaviors

While the primary outcomes of street outreach services may often focus on outreach clients’ experiences and minimizing the adverse effects of rough sleeping, agencies providing outreach services often develop their own indicators and benchmarks for evaluating the impact of outreach activities. These may include:

- Documentation of the number of individuals contacted by outreach teams and workers,
- Multiple contacts with individual clients
- Referrals completed by outreach clients (Anderson, 2008; Greenberg et al., 1998; Measure Y Oakland, 2009).
- Changes in the number of people identified in the streets from year to year (based on consistently administered and analyzed street counts);
- Increases in the proportion of rough sleepers moving from the streets to permanent housing;
- Reductions in systems use among housed individuals (e.g. hospitalization, incarceration);
- Increases in receipt of government benefits for housing
- Successful stabilization in housing as measured through HMIS

**Outreach Workers**

“Some people want the help right off the bat, with others you need to work with them to help them understand what we do… they need to see I am an honest guy who is knowledgeable about the system and can give them help if they want it”. Outreach worker #1

According to Levy (2000), outreach is a relationship-building process, in which the fundamental task of outreach workers is to form and sustain relationships with homeless individuals, rooted in trusting communication, respect for client autonomy and the promotion of client empowerment. Successful engagement is characterized by active listening, sensitivity, and respect for individuals’ rights and decisions (Coughey et al. 1999). Engagement is a process of building trust, which sets the stage for the “real” outreach work to begin (Erickson and Page, 1999).

**Role**

One woman who had been on the streets 27 years recognized the role of outreach worker as one of support, “you need someone to believe in you because you can’t believe in yourself.”

The City of Vancouver (2005) defines the role of street outreach workers as the identification of individuals who are homeless in order to engage them in a positive manner to assess their needs and promote service utilization in areas including basic needs, substance abuse treatment, harm reduction services, health care, income assistance, and facilitate a process to obtain housing. Successful outreach workers establish trusting relationships with both homeless individuals and service agencies (City of Vancouver, 2005). More broadly, outreach workers may assess the ongoing needs of homeless individuals with respect to demographic changes such as an increase in the number of youth or specific cultural groups on the streets, and may compile information on rough sleepers in a geographic area, and keep agency staff informed of health and other issues on the streets including trends in drug use, violence or health issues (McMurray-Avila, 2001; NHCHC, 2002; Randall & Brown, 2006a). Outreach workers should be at the forefront of emerging trends and act as educators to the homeless sector regarding significant changes and threats, such as an outbreak of TB.

**Competencies**

According to Homeless Link (2008), it is important that an outreach worker possesses the ability to build relationships, motivate vulnerable individuals, assess needs and advocate for individuals to access various services. Multiple sources have described additional ideal characteristics of outreach workers. These include:

- flexibility and patience (e.g., able to reassess daily priorities, schedules, treatment processes, etc.)
- a non-judgmental attitude (e.g., letting clients define their own needs, without leaping to conclusions or diagnoses; refraining from judging client behaviours, regardless of personal belief)
- respect for client autonomy and the ability to listen to clients
• realistic expectations
• ability to initiate conversations in a non-threatening manner
• ability to communicate clearly and directly with clients, other outreach workers and other agencies
• tactfulness and diplomacy
• advocacy, to be able to defend clients' rights and negotiate service access for clients, without alienating other service providers
• resourcefulness and creativity with respect to engaging clients and identifying needed resources
• commitment, persistence and consistency in working with clients
• ability to set clear boundaries, particularly regarding worker-client interactions
• assertiveness
• possession of good judgment and “street sense”
• calmness and clear-headedness in emergency or crisis situations
• ability to rapidly assess situations and respond accordingly
• sensitivity to clients' willingness to lead or to be led in outreach interactions and activities
• commitment to team-based service delivery (e.g., knowing when to ask for assistance or seek a second opinion)
• cultural competency/ respect for diversity (formal training/competence for working with individuals of different ethnicity, gender, age, ability, sexual orientation etc.)
• knowledge of community resources
• training in specific issues, e.g. suicide intervention, crisis intervention, family violence/trauma, mental health, and substance use
• resilience (able to continue working despite challenges associated with outreach, such as tracking clients, and witnessing the difficulties experienced by clients) (Brandt, n.d.; Erickson & Page, 1999; McMurray-Avila, 2001; Ng & McQuiston, 2004; NHCHC, 2002; Tommasello et al., 1999; Dozois (2006).

Ng and McQuiston (2004) emphasize the importance of outreach workers’ past experience. For example, more experienced outreach workers may have more realistic expectations, enabling them to more sensitively assess the appropriate timing of interventions. Past experience with homelessness (personal or professional), on the other hand, may help workers understand or relate to clients’ experience on the streets (Homeless Link, 2008).

“I talk with the outreach workers sometimes, it’s good because they know my predicament and they don’t frown on me because I am in this situation. I think they've been there before” – rough sleeper.

In addition to knowledge based on past experience, outreach workers should have strong knowledge of other organizations involved in outreach work, to ensure that efforts can be coordinated as much as possible (McMurray-Avila, 2001). In order to ensure client safety, outreach workers should also be prepared to access emergency services as needed. Finally, they should understand when and how to access detox services, involuntary psychiatric hospitalization and other immediate services (Levy, 2000). It is also essential that outreach workers exhibit sound knowledge of existing community services particularly eligibility, referral processes and program mandates. Outreach workers should
develop strong inter-agency partnerships allowing for a more streamlined system of care. This process is especially critical for outreach workers as there is a limited window of opportunity to engage a client into a program as rough sleepers are more transient and can be very difficult to relocate.

Activities and Principles of Outreach

As with case management, outreach work can be distinguished by what outreach workers and programs do, how they operate and why they do what they do.

Activities of Outreach

Activities or what outreach workers do can be distinguished by four broad categories:

1. information and referrals
2. assessment
3. direct services
4. advocacy

1. Information and referrals

Outreach workers offer information about available services provided by their own agencies or others. A report by Homeless Link (2008) examines a number of “best practice” areas concerning referrals. Above all, relationships between outreach teams and housing programs are considered the determining factor in placement success, as housing teams may trust specific outreach workers to make appropriate referrals and provide accurate and relevant information. Best practice suggests that outreach workers develop clear and consistent referral arrangements based on appropriate referral information. In addition, outreach workers can prepare referrals prior to client contact with services, enabling service providers to review referral information and enabling clients to directly access services when they are ready. The use of HMIS can help to facilitate the referral process by providing real time information on program capacity, criteria and availability.

2. Assessment

Erickson and Page (1999) argue that outreach workers must carry out comprehensive assessments of clients’ needs in order to provide the appropriate services and referrals. Assessments may be formal or informal, and take place over a period of time. Initial assessments are often based on workers' observations and inferences about clients' physical and mental state, but as the relationship between worker and client strengthens, workers may begin to ask more direct questions (Erickson & Page, 1999).

The National Health Care for the Homeless Council (NHCHC) (2002) explains that outreach assessments are continuous activities/processes. Changes among individuals and circumstances necessitate ongoing assessment and re-assessment. Assessments are collaborative efforts, integrating information from client perspectives and worker observations and knowledge.
3. **Direct services**

Outreach teams may provide mental health, harm reduction services, or medical care directly to clients. Outreach teams often assess clients' medical, psychiatric and social needs, and develop safety, and action plans. Outreach workers also provide counseling, crisis intervention services and screening for specific physical and mental health disorders. Further, they may offer social service assistance to clients, focused on accessing housing, benefits/entitlement, identification and other documents. Provision of a service can be an effective tool to engage people in discussions of housing and support programs offered through more formalized case management.

“It was a great way to engage someone because I would be looking up at them and could ask questions such as, “how long have you been here?”, “how long have you been without a home?”, “tell me what happened to get to you this place?”… 90% of the time people would come and see me for a physical alignment, but it allowed the starting point for engagement. It’s all about rapport, trust and engagement… once they feel safe with you that relationship builds and you can begin to develop a plan with that person”. – Outreach worker #2

Examples of direct services provided by outreach teams can include:

- **Safety Planning** – workers may assist clients in identifying concrete actions to increase safety and minimize harm. Safety plans identify information including dangerous places and situations, how to respond to violence, how to escape crisis situations, safe substance use limits, self-defense strategies, important contact, and local resources (violence prevention shelters, safe houses, police, day shelters, free health services, needle exchanges, legal services, rape crisis and related services) (WVPP, 2005).

- **Addressing basic/immediate needs** – workers support clients in meeting needs related to shelter and housing, safety, food, clothing and transportation.

- **Counselling** – outreach workers offer informal supports in coping with trauma, enhancing self-esteem, and enhancing safety and well-being. Workers ask questions, listen, offer encouragement, validate client experiences, identify pertinent issues, identify strengths, support problem-solving and coping skills, assist in identifying goals, and identify and celebrate successes.

- **Education and prevention** – this involves the provision of opportunities for individual learning concerning issues such as cycles of violence, basic life skills, and so on. These activities may also include public education and prevention efforts.

- **Crisis response** – outreach teams respond to crisis situations in the community, based on referrals from the police, other agency workers and members of the public. In these situations, outreach teams may carry out emergency assessments, address immediate safety needs and/or transport clients out of the crisis situation to a safe place (Blagg & Valeri, 2004; Pollack, 1997).

- **Harm reduction** – meeting clients where they are at, outreach workers may provide services to reduce the adverse health, social and economic consequences of drug and alcohol use without necessarily reducing consumption (International Harm Reduction Association, 2010). Some of these services may include needle distribution and recovery programs, supervised consumption and injection sites, and managed alcohol programs.
4. Advocacy

Outreach workers may need to advocate for clients with other agencies, to ensure access to needed services. Outreach workers often engage in what Rowe et al. (1998) term “assertive resource acquisition” within social and health systems. Workers encourage agencies and staff who do not routinely work with the outreach target population and pull referrals from agencies and staff actively working with the target population, but who may often fail to meet their needs. Outreach workers advocate on behalf of individual clients and help them to get past service “gatekeepers”. They may also ensure that clients are following through with referrals working to identify and address barriers to referral follow-up (Dozois, 2006).

Outreach workers may also provide clients with service information, provide service referrals, support clients in scheduling service appointments (health care, financial benefits, housing, and so on), schedule appointments on behalf of clients (with clients’ permission) and/or accompany clients to appointments.

Outreach and Case Management

If outreach is considered the first point of contact in engaging rough sleepers off the streets and into support programs, then case management is the intervention that can sustain housing and prevent return into homelessness. Once a rough sleeper has been engaged by an outreach worker, assessed for need and program eligibility, and has initiated a referral, a transitioning period commences whereby the individual becomes a client of a program and is assigned a case manager. The case manager will facilitate the move into housing and provide the continued support necessary to maintain housing.

Outreach workers and case managers represent two different roles, yet are mutually dependent in service delivery for rough sleepers. Outreach workers engage individuals at the street level in a non-judgemental, client centred capacity. They work with rough sleepers to foster positive sense of self, provide information about available services and promote harm reduction.

Transitioning the relationship from an outreach worker to a case manager is important for a number of reasons. Primarily, the central role of the outreach worker is to engage people at the street level – outreach workers thus do not have the capacity to carry a case load of additional clients who are in a program. Secondly, outreach workers and case managers employ different mandates and exhibit different skill sets. Outreach workers help to facilitate access to services and case managers aid the clients once they are there. The transitioning between workers can however be complex and may not always be successful. Local outreach workers discussed the dilemma experienced by their clients whereby they felt abandoned and overwhelmed during the process of transition. This risk can be mitigated through transparent dialogue with clients about the transitioning process and maintaining limited engagement through the process.

Shared qualities for outreach workers and case managers include:

- focused on the right matching of services
- person-centered
- adaptive
- individualized
• culturally appropriate
• flexible
• holistic
• long-term
• multi-disciplinary
• include advocacy that leads to self-advocacy
• focused on establishing networks and relationships
• include coordination and engagement (Calgary Homeless Foundation, 2011)

Principles for Successful Outreach

“It is our reality that we want them in housing, for the people that sleep under the bridges that is their comfort level, so they might fantasize about housing the way we fantasize about Beverly Hills, but it’s just fantasy and when that’s about to come true a lot of them just… they’re afraid I guess. There is a lot of responsibility to being housed, many of which they can’t even conceive of…” – Outreach Worker #4

A number of principles have been identified as characterizing successful outreach. These include:

1. **Consistent and trusting relationships**

Ng and McQuiston (2004) explain that the outreach process is centered on the development and maintenance of a trusting relationship between workers and clients. Previous experiences of judgment and stigmatizing attitudes acts as a deterrence to system utilization and makes the engagement and relationship building with outreach workers all the more important, as this relationship can begin to rectify mistrust of services and the trauma of belittling behaviors and attitudes.

2. **Consistent and Honest Communication**

Levy (2000, 2004) explains that the outreach and engagement process involves the development of a common language between workers and clients to enable the full consideration and exploration of possibilities for healthy changes from a common frame of reference. When outreach workers pay attention to subtle meanings in client language, they can learn to use language to form meaningful connections with homeless individuals. As part of this process, workers attempt to genuinely comprehend and respond to the words and gestures communicated by their clients, moving beyond a strict focus on illness and treatment only. Central aspects of common language development include identification and understanding of a client's words, concepts, and values, as well as time for clients to become familiar and comfortable with words and phrases used by outreach workers.

3. **Consistent and Assertive Approach**

Randall and Brown (2002, 2006b) promote an assertive and persistent approach to street outreach focused on motivating individuals to access supports and accommodation. This approach involves daily attempts at contact with individual clients, repeated contact made with
individuals initially unwilling to engage and actively discouraging individuals from sleeping rough while advocating the advantages of moving into accommodation.

Frequent contact between outreach workers and clients is a central component of assertive outreach and can increase the likelihood of successful engagement, appropriate interventions and completed service referrals (Greenberg et al., 1998; Rosenblum et al., 2002). A concern raised among rough sleepers in Calgary was the “disappearance” of their workers and their frustration with not knowing the progress of their plans, such as applications for housing, treatment, or vocational training. Furthermore, precarious and inconsistent engagement and communication with clients can lead to a sense of abandonment and further mistrust in public systems and staff.

4. Client Choice and Empowerment

Adherence to a client-centered approach provides clients with choice and control over the process of exiting the streets, and can be considered a strategy for enhancing confidence and empowerment. Anderson (2008) emphasizes the importance of enabling outreach clients to make their own choices, citing one outreach worker who explains: “You have to give some people a little room... When I go back and speak to [the client] again, the whole response is going to be different. I’ve empowered him to make decisions when I give him a few cards and say, ‘Look, somebody runs into you with a problem, give me a call’” (Anderson, 2008, p. 8).

Available services ought to be introduced at a pace that is comfortable for clients. Enhancing autonomy by offering choices can be very effective while developing the client’s life skills and capacity to live independently (Ng and McQuistion 2004).

Erickson and Page (1999) explain that workers should respect and empower clients during their recovery, understanding that behavior changes take place on a continuum and the recognition of small successes is extremely important. Outreach workers aim to instill a sense of hope among clients, while maintaining realistic and positive expectations. Unrealistic expectations may result in feelings of frustration, despair, hopelessness or anger among clients. Workers support clients in reframing expectations and disappointments, and communicating that changes may take considerable time, effort, and patience (Erickson & Page, 1999).

The process may also involve addressing feelings of low self-esteem and fears, ensuring clients can access services, resources and benefits to which they are entitled, and maintaining contact with clients even when they are no longer sleeping rough (Broadway Homelessness and Support n.d.).

5. Harm Reduction

Harm Reduction is a critically important principle of effective outreach. It is a means through which outreach workers can establish trusting relationships with homeless individuals, promote safety and continuously monitor safety issues while intervening as needed (Levy, 2000). A harm reduction approach “involves providing a broad range of risk reduction, health, social and related services (Appel et al., 2004, p. 131). Harm reduction involves a non-judgmental and respectful approach; assisting clients in identifying harmful effects of drug and alcohol use as well as benefits of decreasing or ceasing use; exploring alternate and safer activities; celebrating small successes; and developing flexible plans to address substance abuse issues (Erickson & Page, 1999).
“You can’t refuse services based on requirements of sobriety. Need to be non-judgemental and expect that you will encounter all sorts of different people. You can’t be judgemental because you are not going to be able to develop those relationships and they won’t come to you when they are in trouble” – Outreach worker # 4.

Examples of harm reduction techniques or interventions might include the facilitation of self-help attendance, needle exchange programs and concurrent education about detox and drug rehabilitation services/programs, distribution of bleach kits, the provision of essential items such as warm blankets, clothing and food, and low-threshold harm reduction counseling (Kayman et al., 2005; Levy, 2000; Scandlyn et al., 2005). A harm reduction approach emphasizes goals other than abstinence, such as learning more about addiction, treatment and recovery, and reducing the risks, negative effects and harm associated with substance use (Kayman et al., 2005).

6. Housing First

A street outreach worker is often the first point of contact for people sleeping rough. An important principle is the belief that anyone can be successful in housing if they have the proper supports in place.

A number of studies have described “Housing First” outreach program models, which are based on the belief that providing clients with immediate housing access establishes a foundation upon which they can begin the process of recovery (Falvo, 2009; Tsemberis et al., 2003; Tsemberis et al., 2004). The Housing First program emphasizes the importance of client choice and is designed to address self-identified client needs and goals. Clients are provided an apartment without psychiatric treatment or sobriety prerequisites. Housing First programs often include Assertive Community Treatment (ACT) teams, which provide treatment, support, and other services to clients. These interdisciplinary teams are often made up of social workers, nurses, psychiatrists, vocational counsellors and substance abuse counsellors who are available to support clients 24 hours a day, seven days a week.

7. Cultural Practices

“For a lot of the Aboriginal folks who grew up on the reserve, they haven’t seen it in forever and [going back] gives them a pretty good memory, helps them to remember who they are, other than social work and psychology that’s available to them now that doesn’t really have an effect on Aboriginal peoples. We give them the opportunity to talk to Elders, a lot of people participate in that… there is something in our DNA when we sit down with an old person everything just falls into place” – Outreach worker #5

The broad approaches described above facilitates the provision of various outreach services to rough sleepers whose unique needs may differ widely. For outreach targeting rough sleepers of Aboriginal heritage, however, a slightly different approach may be more culturally relevant and appropriate.

Aboriginal outreach workers in Calgary expressed a lack of awareness amongst mainstream homeless-serving agencies regarding Aboriginal culture and history. They were concerned that this lack of awareness can lead to a perpetuation of stereotypes and misinformation about Aboriginal people and their experiences/pathways into homelessness.
“We need a lot of re-education, the people running around doing the Aboriginal awareness don’t know it themselves, you can’t learn from a book or the internet, you need to come to the people, come and pray and sweat. I have been at agencies and overheard some of these misconceptions, ‘oh you can’t look an Indian in the eye’… so there is a lot of misinformation about the Aboriginal culture and that is a barrier in itself” - Outreach Worker # 6.

In 2005, Social Data Research carried out an evaluation of services for Aboriginal homeless individuals in Ottawa, based on consultations with Aboriginal and mainstream service providers, Aboriginal clients and other stakeholders. A round-table was facilitated with members of the Aboriginal Coalition and existing data was analyzed, including a city service inventory, a national agency database and Ottawa Aboriginal agency statistics. Based on interviews with key informants who had experience in Aboriginal-specific programs, a number of “best practices” were identified:

- service delivery models based on tradition and culture;
- service delivery models intended to empower clients to determine their needs and desires, and to make their own decisions;
- gathering information about community needs from Aboriginal individuals, including those who are homeless;
- intensive case management and comprehensive services addressing all aspects of healing, including physical, emotional, mental and spiritual; and
- addressing issues of trauma, violence and substance abuse through long-term treatment.
Section 3: Developing Dimensions of Practice for Effective Street Outreach

The information above sets the context specific to unique needs of rough sleepers, the relationship between outreach and case management and clarification of the expected outcomes for outreach when working with homeless people. The following section clearly articulates key challenges or lessons learned, and promising practices identified in both the existing research and from Calgary’s study with outreach workers and rough sleepers. These are key considerations towards development of standards of practice for street outreach in ending homelessness.

Part 1: Lessons learned

Factors influencing that can create barriers to success in outreach programs include those associated with individual client issues and service and systems issues.

Individual Issues

Hough and Rice (2010) describe a strong resistance and even antagonism toward service providers from some rough sleepers. Outreach workers were often viewed as part of the “establishment”, aiming to force rough sleepers into accommodation they may not want to access. Many participants reported having very negative views about available services prior to the start of the project. These negative views extended from outreach services and shelters to the broader “system” and were often based on negative personal experiences, sometimes from many years ago.

A high level of anxiety is often associated with moving into accommodation after having spent several years sleeping rough. The longer that people sleep rough, the more they adapt their behaviour to survive homelessness, the more they experience social exclusion and the more entrenched they become in the street homelessness experience. This may result in a sense of hopelessness, whereby people find it very difficult to re-engage with mainstream services and society (Chamberlain et al., 2007).

“It’s frustrating when you have high needs clients, clients who have been out there a long time, and you get them housed and in the middle of the night they go back to the streets because they are scared of their house” – Outreach worker # 4.

Often homeless individuals prefer the relative independence of street life (Tsemberis et al., 2004). Hough and Rice (2010) report for many rough sleepers, freedom from all aspects of financial responsibility, was an important reason for choosing street life. Furthermore, rough sleepers identify a sense of autonomy living outdoors as opposed to living in abidance of shelter rules.

Even when individuals recognize the potential benefits of service access, they may reject it because of negative past experiences they’ve had with clinicians and treatment centers (e.g., involuntary hospitalizations). Levy (1998) explains that many homeless individuals have experienced multiple failed relationships, causing them to be fearful and cautious with respect to beginning new relationships with outreach workers. They may also lack skills and boundaries necessary to establish and maintain healthy relationships.
Service and Systems Issues

“If someone does come up to you and says I want to get sober, I want my life to be different, but then there is a 2 month wait list for treatment what do you say? Just hold that thought and come find me in 2 months? That’s how you lose a lot of these guys, even if they go through… and do a detox, they get out and are back on the streets and they end up drinking again” – Outreach worker #6.

According to McMurray-Avila (2001), one of the most significant barriers to effective outreach work is a lack of resources to which clients can be referred, once they are ready and willing to accept services. Outreach work is only successful when immediate access to services/placements is available. These efforts can be disrupted by a lack of housing options, treatment program waiting lists, and so on. As such, outreach workers may not be able to deliver on promised services.

Outreach services which are “accessible” are not always “acceptable” to certain individuals. Urgent or immediate concerns like obtaining food, clothing, and shelter may take precedence over treatment for some individuals (Tommasello et al., 1999). A person’s sense of immediacy and desire to fulfill basic needs often conflicts with the extended process of treatment, as well as with the “office culture” of scheduled appointments central to many services (Levy, 2004).

Additional barriers identified by participants in the Calgary study include:

- transportation to treatment sites (for example, shelters may be located in areas poorly serviced by public transit systems, or individuals may require access after buses have stopped running);
- difficulty in finding clients for follow-up;
- negative attitudes toward drug users from program staff (e.g., that clients with substance abuse issues are disruptive or too difficult to help);
- a lack of appropriate programs (e.g., for individuals with co-occurring addictions and mental health concerns, individuals working shifts, individuals with pets, individuals using alcohol or drugs, and others);
- a lack of culturally appropriate program spaces;
- strict treatment program attendance and compliance standards; and
- a lack of storage space for personal belonging should someone choose treatment (Appel et al., 2004; City of Vancouver, 2005; Randall & Brown, 2006b; Slesnick et al., 2007).

The following were identified by rough sleepers as issues in Calgary’s local context:

- lack of housing;
- financial barriers;
- a lack of case managers;
- waitlists;
- criminal justice involvement (outstanding warrants)
- Negative past experiences resulting in being barred or “black listed”;
- Staff turnover “good outreach requires experienced workers with a good reputation on the street”; Outreach worker #7
- non-judgemental workers; and
- misconceptions about the types and eligibility of service.
Calgary Outreach workers added:

1. navigating the myriad of services;
2. barred/blacklisted clients;
3. previous eviction due to not paying rent; and
4. staff turnover and the time needed for re-engagement.

**Overcoming Issues**

Individuals who enter programs incompatible with their needs and abilities tend to return to the streets. These individuals tend to be less trusting in future interactions with outreach workers, which can exacerbate the difficulty of practicing effective outreach (Coughey et al., 1999). This illustrates the need to address challenges to outreach work and to ensure that clients have access to a range of service and accommodation options, with the ability to choose the most appropriate services and accommodation to fulfill their unique needs.

Individuals will participate in outreach services when they can see benefits associated with doing so and when they believe that they have control over the use of those services. Suggestions for addressing enrollment barriers included dropping ID and insurance requirements for program admission, funding the transportation of outreach client treatment candidates to service sites, improved inter-agency cooperation, program modification to better meet client needs, particularly from a harm reduction framework, increased education of outreach clients regarding treatment/service options, and the integration of harm reduction and public health aspects of addiction treatment (Appel et al., 2004).

According to Coughey et al. (1999), appropriate placements are key to the success of outreach initiatives. Outreach staff can ensure appropriate placements and housing success by providing homeless individuals with information about housing options, rules and regulations, as well as by providing introductions to on-site staff (Coughey et al., 1999). Some outreach clients may refuse to access certain city shelters or certain mainstream services. Outreach workers ought to respect these feelings and look for alternative placements. Whenever necessary, they should provide clients with a list of different possibilities for housing, employment, substance abuse treatment, and so on (Anderson, 2008).

Linking rough sleepers to opportunities for social inclusion and community reconnection and reintegration is a central focus of outreach services and an opportunity to begin the case management process (Christensen, 2009; Erickson & Page, 1999). Outreach services aim to offer social support and a point of contact for outreach clients (Christian & Abrams, 2004).

The creation of social networks is a significant element in the “reconstitution” or reintegration for rough sleepers. Rough sleeping can be considered the ultimate form of social exclusion, as individuals may not have any social or familial affiliation while living on the streets.

Hodgetts et al. (2007) explained that while basic needs such as shelter and food are important, equal importance ought to be assigned to facilitating social support, community and friendship: “It would be misleading to assume that physical and material needs must be addressed before psychological and relational health can occur... participants sought both basic material needs and meaningful social supports” (p. 716). The fulfillment of both basic needs and social supports are necessary to ensure client health, as social relationships greatly influence homeless individuals' circumstances, coping abilities and survival strategies (Hodgetts et al., 2007).
Section 4: The 8 Dimensions of Promising Practice

1. Interagency and Inter-sectoral Collaboration

Outreach teams work to establish and maintain relationships with other agencies such as emergency shelters, mobile health units, housing and support providers (Farrell et al., 2005; NHCHC, 2002). Outreach workers may visit several community agencies and service providers on a daily basis in order to form close and comfortable relationships with the operating staff (Fisk et al., 1999; Ng & McQuiston, 2004).

It is important for outreach workers to develop positive relationships with intake workers at agencies to which their outreach clients might be referred (Erickson & Page, 1999). Close work between outreach teams and agencies in regular contact with rough sleepers facilitates joint planning for individual clients, as well as broader rough sleeping populations, ensuring the coordination of appropriate actions between all services (Randall & Brown, 2006b).

Stergiopoulos et al. (2010) emphasizes the importance of formalized collaborative relationships and service agreements among agencies from different sectors, providing a continuum of services and supports for homeless individuals. Service integration is central to effective outreach, as outreach clients are often in need of a range of supports. Access to services can be streamlined through agency partnerships (City Spaces Consulting, 2007; Stergiopoulos et al., 2010).

Interagency collaboration can improve access to government benefits by reducing administrative barriers and creating a more comprehensive system of supports (Rowe et al., 1998; Stergiopoulos et al., 2010). Further, the development of continuous services ensures meaningful and consistent client support without the obstacles normally caused by organizational boundaries. This is accomplished by breaking down barriers between agencies with such activities as ‘case conferences’, which bring various agencies together to focus on vulnerable clients and develop service linkages (Griffiths, 2002).

Ng and McQuiston (2004) recommend that outreach programs establish coherent linkages to shelter, benefits/entitlement, emergency services, medical care and law enforcement systems. Randall and Brown (2006b) outline recommendations for successful joint work between agencies including agreement (from the outset) on the roles and responsibilities of all participating agencies; effective information-sharing between agencies; joint visits and training between agencies; and an identified individual agency or worker to facilitate the joint work process.

Regular case conference meetings of front-line agencies are a key practice during which agencies would review the needs and agree on actions concerning individual rough sleeping clients. This practice can also ensure outreach workers stay up to date on program waitlists, eligibility criteria, and new staff.

Calgary outreach workers added that consistent and ongoing meetings can help with referrals, if for example an outreach worker comes across people who are Aboriginal and who want cultural supports but the program they represent does not provide that. A specific partnership frequently discussed is outreach teams’ cooperation with the local police or law enforcement. Partnerships between outreach teams and the police are based on the recognition of the importance of helping
homeless individuals address important, life-and-death issues, such as substance abuse, mental illness, sexual exploitation, and so on (Anderson, 2008).

In many cases, police partnerships may help to strengthen outreach work. Police officers can take action against violence or drug dealing, but may also encourage rough sleepers to access available homeless services, and provide information on available accommodation and services (Randall & Brown, 2002).

Partnerships between outreach teams and the police can also cause a shift in police approaches and beliefs with respect to homeless individuals, and can serve to increase police awareness of available services. Police officers can then pass outreach information to homeless individuals on their own (Anderson, 2008; Randall & Brown, 2006a).

Calgary’s PACT team, a partnership between Police and Alberta Health Services is an example of a collaborative outreach team that works together to refer people with mental health concerns and who are often experiencing homelessness into supports as opposed to taking a strictly enforcement approach.

In addition, Calgary’s Centre City Team includes community peace officers who work collaboratively with a variety of city and service groups to facilitate the movement of rough sleepers from the streets into housing programs.

2. Team-Based Approach

Outreach work involves three relationship types: between individual workers and clients, among outreach team members, and between the entire outreach team and individual clients. This last relationship type can be related to a team-based case management approach. While formal professional roles are of significance, these roles are often more fluid in outreach work (Ng and McQuiston, 2004).

Following a “team approach” to outreach service provision and case management, workers act together, make joint decisions and share responsibility for individual clients (Homeless Link, 2008). All team members ultimately play some type of clinical role during their interactions with clients, enabling clients to develop trusting relationships with multiple workers, which in turn increases the likelihood of them receiving needed assistance (Erickson & Page, 1999; Ng & McQuiston, 2004). Team-based caseloads versus individual caseloads enable more intensive and collaborative work to be carried out with all rough sleepers, who can have contact when any outreach team member is engaging in street work, rather than waiting to meet with a specific worker (Randall & Brown, 2006b).

Brandt (n.d.) reports on over two decades of street outreach services provided to homeless individuals by Ottawa Inner-city Ministries in Ontario. Outreach teams adhere to a team-based model of case management and service provision whereby clients are encouraged to rely on services rather than individual workers, and work is assigned based on daily client needs and crises. The success of this team model is based on worker flexibility and communication. Weekly case management meetings review the situations of all current clients, identify needs and discuss strategies for assisting individual clients.

As part of a team-based outreach approach, record-keeping and information sharing are of extreme importance. A streamlined approach to data management within an outreach team facilitates
consistent and reliable support of outreach clients (Homeless Link, 2008). Joint agency work is significantly enhanced by bi-weekly case management meetings focused on individual clients and monthly meetings focusing on multiple clients. Meetings may include agency service workers and managers, street outreach workers and representatives from mainstream systems. Agencies can also exchange updated lists of clients on a weekly basis and maintained regular telephone contact (Randall and Brown, 2006a).

3. Continuum of Supports

In order to effectively respond to the diverse experiences and needs of rough sleepers, a variety of outreach programs, housing and support options must be in place across a continuum of supports. If it is not feasible for every outreach team to include the variety of workers discussed in this report, then streamlined and timely referrals must be made to ensure people do not slip through the cracks.

Harm reduction philosophy and practice should provide a framework for the continuum of supports offered in outreach. Rather than coercing clients into seeking services that are unrealistic given their current circumstances, the services offered by outreach workers should be grounded in a client’s current needs so as to facilitate a move towards seeking help and housing by meeting clients where they are at. Thus, the options offered by outreach workers should be incremental with more feasible options offered to begin with (e.g., those that keep clients safe).

In addition to a range of housing programs, from low intensity rapid re-housing to medium and high intensity case management, as well as options for permanent supportive housing, a continuum of care should include common intake, and assessment tools and practices by outreach teams regardless of who is engaged or by whom.

Specialized accommodation and services should be established to support vulnerable groups, such as youth, Aboriginals, older adults, women, individuals leaving prison, individuals leaving health, drug or alcohol treatment programs, and individuals with mental health issues and sexual minority individuals. Members of vulnerable sub-populations may not feel comfortable accessing shelters or other services with members of the general population (City of Vancouver, 2005; FEANTSA, 2004; Homeless Link, 2008).

Inclusion of a standardized HMIS system that collects and shares client level data as well as common reporting outcomes and outputs is also recommended as a way of reducing barriers to service access and strengthening the system of care (SAMHSA, 2009).

4. Diverse Outreach Teams

A range of ages, skills, experiences and cultural backgrounds amongst outreach workers can maximize the chances of successful engagement with diverse outreach clients (Homeless Link, 2008). Effective outreach teams encourage expertise and input from diverse team members when engaging and supporting clients. For example, a nurse on an outreach team can identify and evaluate clients’ medical concerns which may not have been detected by other team members (Ng & McQuiston, 2004). As well, inclusion of an Aboriginal outreach worker can help reduce barriers and facilitate engagement with rough sleepers who are Aboriginal.
Examples of outreach teams include:

- a team facilitating housing access for rough sleepers with a severe mental illness, personality disorder, disability and/or untreated medical needs, composed of psychiatrists, a housing case manager, a street outreach case manager and a concurrent disorders specialist (Stergiopoulos et al., 2010);
- a team providing “Housing First” community treatment services, composed of social workers, nurses, psychiatrists, vocational counselors and substance abuse counselors (Tsemberis et al., 2004);
- a mobile psychiatric team providing assessments and mental health services to homeless individuals, composed of an addictions worker, an occupational therapist, a psychiatric nurse practitioner, a psychologist, a recreational therapist and various social workers (Farrell et al., 2005); and
- a team providing specialized outreach and housing services to homeless individuals with severe mental illnesses and/or substance abuse disorders, composed of mental health and substance abuse experts, emergency shelter workers, a nurse practitioner, the police and a peer outreach worker (Coughey et al., 1999).

5. Peer Support

The inclusion of peer outreach workers in street outreach teams is described and promoted in a significant amount of existing research. ‘Peers’ may include current or former rough sleepers and service users, as well as members of the outreach program’s target population. Peer clinicians and other workers often play a more prominent role in outreach work than in more traditional multidisciplinary service teams (Ng & McQuiston, 2004).

Erickson and Page (1999) emphasize the value of peer-based outreach, stating that the expertise of homeless and formerly homeless individuals and service consumers ought to be valued and actively sought out, as they can enhance outreach effectiveness by sharing personal expertise and fostering relationships between workers and clients. Peers are more familiar with the risks and concerns of the target population, and can be effective educators and advocates (Latkin et al., 2004). Individuals with lived experience can bring unique insight to outreach teams and can suggest coping strategies to outreach clients struggling with similar issues (Fisk et al., 2000).

Peer outreach workers can engage potential clients in ways that can minimize the distance between clients and the outreach team. Ng and McQuiston (2004) explain that peer outreach workers can bring unique attributes to outreach work, due to their personal experiences of homelessness. They report that the inclusion of peer clinicians in outreach teams encourages teams to be more proactive with respect to interventions and advocacy and to be more aggressive in locating services for clients.

Outreach workers who are former service users can better relate to their clients’ realities and may be more self-confident and assertive in encouraging entrenched rough sleepers to exit the streets. The outreach relationship-building process requires flexibility, creativity, and attention to client-expressed needs and priorities. Former service users have reported that listening skills, perseverance/persistence, small steps, and frequent contact by outreach workers are especially beneficial in building relationships (Homeless Link, 2008).
Results from Calgary’s study added two further advantages to inclusion of peer workers on street outreach teams. First, peer workers can increase the sustainability of housing if they can reduce the social isolation people often feel when moved from the streets into permanent housing.

Second, when dealing with Aboriginal peoples, having an Aboriginal outreach worker was helpful when they spoke a common language, and had their own stories to share of their families, communities and cultural traditions.

6. Training for Staff

Outreach workers need to be supported with training on a range of inter-connected issues. Which include:

- street safety
- characteristics of the target outreach population
- pathways into and out of homelessness
- the relationship between mental illness and addictions to homelessness
- domestic violence
- dual diagnoses
- criminal justice and legal issues
- benefits and entitlements
- community resources
- client rights
- harm reduction
- confidentiality
- crisis assessment and crisis intervention techniques
- conflict mediation
- anger management
- healthy boundaries
- basic first aid and CPR
- regional legislation
- effective engagement strategies
- cultural competency
- infection control and other health issues
- counselling skills (Appel et al., 2004; Christensen, 2004; Dozois, 2006; Erickson & Page, 1999; Levy, 2000; NCCD, 2009).

The NCCD (2009) argues training needs vary significantly between outreach programs and no standardized street outreach training program or curriculum exists. Outreach programs often rely on ‘on the job’ training, where new outreach workers accompany experienced workers for a certain period of time (e.g., one month) until they are appropriately acquainted with the program, services offered, target population, and so on. However, the NCCD also states that standardized training is of
importance in professionalizing street outreach work, providing outreach workers with skill development and promoting career advancement.

Training might also be provided to workers from agencies working in partnership with outreach teams and to outreach workers themselves. Farrell et al. (2005) describe the Psychiatric Outreach Team in Ottawa, Ontario, the outreach team works with over 50 community-based partner agencies, including service providers in shelters, residential care homes, community health centres, drop-in centres, low-income housing and supportive living environments. Before the partnership began, many of the staff at the community-based agencies had little or no formal training in social services. As a result, the outreach team provided education and consultation to agency staff about mental illness, medication, behavioural strategies to work with clients and methods used to facilitate access to additional resources. This empowered community agencies to work more effectively with their clients.

7. Boundaries and Standardized Safety Protocols

The physical environment in which outreach work is carried out has the potential to be dangerous (Ng & McQuiston, 2004). Outreach workers may be entering unknown areas such as camps, vacant buildings, and dark alleyways where individuals may not be expecting them and/or are not willing to receive them. In addition, some individuals targeted by outreach services may be involved in illicit or violent activities, making outreach workers more vulnerable to some forms of violence (McMurray-Avila, 2001; NCCD, 2009).

Fisk et al. (1999) explain outreach and engagement activities draw outreach workers outside of traditional clinical practice, as workers shift from rigidly-defined office/agency settings to less formal community settings, such as shelters, soup kitchens and other community sites. This shift requires that workers constantly redefine clinical practice in areas such as boundaries in client relationships, safety, and professional ethics. Fisk et al. (1999) examine these issues, drawing on the general experiences of homeless outreach workers:

Boundary issues arise when these spaces become sites of clinical activities. Physical boundary issues may come into play when approaching and engaging with outreach clients, such as the right to privacy on the part of homeless individuals in public spaces.

A number of strategies to enhance outreach worker safety have been identified:

- Outreach work should be carried out by teams of at least two people and outreach workers avoid working alone;
- Outreach workers should ensure that other agency workers are aware of their location at all times and workers carry a mobile phone;
- Outreach workers should be cautious and alert at all times and assess situations prior to engaging with potential or current clients;
- Outreach workers should avoid enclosed or remote areas or ensure they assess risk before entering;
- Outreach workers should receive training focusing on addressing risky situations; and
• Outreach workers should always carry identification and business cards (Erickson & Page, 1999; Fisk et al., 1999; Homeless Link, 2008; McMurray-Avila, 2001; NCCD, 2009; NHCHC, 2002; Winchester, 2010).

8. Professional Ethics

Outreach workers work largely outside the purview of the agencies that oversee their work. This can result in a lack of direct oversight from the worker's agency, and work activities occurring which may not be directly supervised by program managers. Additionally, outreach workers must be sensitive to how, where, and when they approach potential and current clients. Whenever possible, outreach workers should allow clients to take the lead in beginning and ending interactions, in order to avoid (inadvertently) breaching confidentiality in community settings.

The diverse background of outreach workers and the blurred boundaries that come with working outside of an agency/program structure can create a myriad of ethical issues for outreach workers. In addition, personal and professional values and beliefs can create ethical conflicts when perceptions about substance use influence a worker's attitude when working with someone who has addictions issues.

Knowledge of client rights and use of respectful language and techniques should align with professional ethics used by other groups of professionals, such as social workers or case managers. There are several professional codes of conduct that could be applied, however "consistency across the different codes dictates that [professionals] must always: promote the best interests of the person, do no harm to others, be fair and reasonable in the treatment of others, be respectful and ensure confidentiality, and be socially just in their decision making" (Calgary Homeless Foundation, 2011, p. 29).

Conclusion

Street outreach involves the active identification and engagement of rough sleepers on the part of outreach workers. Outreach services target the most vulnerable and entrenched homeless individuals living on the streets, with the aim of meeting basic needs, facilitating housing access, increasing service utilization, and ultimately, achieving social inclusion. Outreach client groups might include individuals with substance abuse concerns, individuals with a mental illness, individuals with health concerns (such as HIV), women, youth and Aboriginal people.

Successful street outreach programs are typically rooted in a service approach, emphasizing and beginning with the development of trusting relationships between outreach workers and clients, assertive outreach practice involving the active encouragement of service use, and frequent contact between workers and clients, a harm reduction philosophy emphasizing gradual change towards improving health and stability, and a client-centered focus, emphasizing client choice, control, and empowerment in the outreach process.

Outreach activities can include information and referral, assessment, direct service provision and advocacy. These activities may be carried out using a range of outreach strategies, in diverse outreach sites, as outreach workers engage in a variety of processes of client identification and engagement.
Outreach work should be carried out in partnership between outreach teams and relevant community agencies and institutions, such as shelters, Housing First programs, health care facilities and the police. As a result, individual clients and client groups are supported by a team-based process, in which diverse outreach workers and agencies contribute expertise and available resources.

Street outreach can be an effective means of engaging rough sleepers in accommodation and services, reducing the number of homeless individuals living on the streets, in turn reducing the number of homeless individuals in a given community. It can be argued without the implementation of outreach services, homelessness can never be completely addressed. Rough sleepers represent a population of homeless individuals who are unlikely, unwilling, or unable to engage with existing services on their own, and will remain homeless without targeted intervention or assistance. As such, specifically targeted services are necessary. Homelessness cannot be ended unless rough sleepers are supported in leaving the streets, and strategies to reduce or end homelessness will not be entirely effective unless they are rooted in promising practices designed with the unique and diverse experiences and needs of rough sleepers.
References


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